OKLAHOMA DEPARTMENT OF CORRECTIONS
AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

SECTION I.

INDIVIDUAL'S/PATIENT'S NAME	BIRTHDATE	ODOC NUMBER	SOCIAL SECURITY NUMBER

I, the individual/patient above, request the following protected health information (PHI), from (date) _____ to (date) _____ be released by the Oklahoma Department of Corrections (ODOC) to the recipient named below:

RELEASE COPIES OF MEDICAL RECORDS TO:	OBTAIN COPIES OF MEDICAL RECORDS FROM:

☐ Release Medical Records To: ODOC staff involved in the Medical Parole Process, Oklahoma Pardon and Parole Board staff and Pardon and Parole Board members for the Medical Parole Process, Governor and governor's staff involved in the Medical Parole Process. Note: I understand that my medical record may be discussed in an open Parole Board Meeting

☐ ENTIRE MEDICAL RECORD (Excludes Mental Health/Psychiatric/Psychological Records and Psychotherapy Notes)

OR ONLY THESE PORTIONS OF MY RECORDS:

☐ MENTAL HEALTH/PSYCHIATRIC/PSYCHOLOGICAL* ☐ RADIOLOGY ☐ LAB WORK ☐ DENTAL ☐ OPHTHAMOLOGY
☐ PSYCHOTHERAPY NOTES (If checking this box, no other records may be selected)
☐ OTHER _____
* Excludes Psychotherapy Notes

PURPOSE OF REQUEST: ☐ CONTINUITY OF CARE ☐ MEDICAL PAROLE ☐ LEGAL ☐ OTHER _____

SECTION II. DENIAL/LIMITATION OF ACCESS TO MENTAL HEALTH RECORDS (TO BE COMPLETED BY DOC)

☐ Request for Records Approved ☐ Request for Records Denied ☐ Request for Records Permitted but Access to Inmate Limited****

_____
Signature of DOC Provider/Professional Facility Date

SECTION III. FOR INMATE MEDICAL RECORD REVIEW ONLY

This is in addition to the completion of the above information. This will be utilized if the records are only made available to an inmate to review, once complete.

Inmate's Signature:	Date of Review:	Time:
Reviewer Signature:	Date of Review:	Time:

SECTION IV. AUTHORIZATION and EXPIRATION

EXPIRATION: This authorization will remain in effect for**:**

☐ Expires on the following date: _____
☐ Expires 90 days from the date of signature and date below
☐ Expires at the end of incarceration

If expiration is not designated the automatic expiration date of this Authorization will be twelve (12) months from the date of signature.

****May be requested to show proof of representative status**

_____
Offender Date

_____
Legal Representative/Guardian Describe authority to act on behalf of the individual Date

SECTION V. ACKNOWLEDGEMENTS

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION RELEASE OF PSYCHIATRIC/PSYCHOLOGICAL RECORDS

I. ATTORNEY, A THIRD-PARTY PAYOR, OR A GOVERNMENTAL ENTITY

OKLAHOMA TITLE 43A, SECTION 1-109 (D) PROVIDES, "EXCEPT AS OTHERWISE PERMITTED, MENTAL HEALTH AND ALCOHOL OR SUBSTANCE ABUSE TREATMENT INFORMATION MAY NOT BE DISCLOSED WITHOUT VALID PATIENT AUTHORIZATION OR A VALID COURT ORDER ISSUED BY A COURT OF COMPETENT JURISDICTION. FOR PURPOSES OF THIS SECTION, A SUBPOENA BY ITSELF IS NOT SUFFICIENT TO AUTHORIZE DISCLOSURE OF MENTAL HEALTH AND ALCOHOL OR SUBSTANCE ABUSE TREATMENT INFORMATION."

II. INMATE ACCESS TO PSYCHIATRIC/PSYCHOLOGICAL RECORDS

The execution of an authorization shall not be construed to authorize the inmate personal access to the records or information, unless the treating physician or practitioner signs the following or an order from the court or competent jurisdiction is provided. Any violation will be reported to the appropriate authorities.

45 C.F.R. § 164.524 PROVIDES IN PART, "A COVERED ENTITY THAT IS A CORRECTIONAL INSTITUTION OR A COVERED HEALTH CARE PROVDER ACTING UNDER THE DIRECTION OF THE CORRECTIONAL INSTITUTION MAY DENY, IN WHOLE OR IN PART, AN INMATE'S REQUEST TO OBTAIN A COPY OF PROTECTED HEALTH INFORMATION, IF OBTAINING SUCH COPY WOULD JEOPARDIZE THE HEALTH, SAFETY, SECURITY, CUSTODY, OR REHABILITATION OF THE INDIVIDUAL OR OF OTHER INMATES, OR THE SAFETY OF ANY OFFICER, EMPLOYEE, OR OTHER PERSON AT THE CORRECTIONAL INSTITUTION OR RESONSIBLE FOR THE TRANSPORTING OF THE INMATE."

OKLAHOMA TITLE 43A § 1-109 B. PROVIDES IN PART, "A PERSON WHO IS OR HAS BEEN A CONSUMER OF A PHYSICIAN, PSYCHOTHERAPIST, MENTAL HEALTH FACILITY, A DRUG OR ALCOHOL ABUSE TREATMENT FACILITY OR SERVICE, OTHER AGENCY FOR THE PURPOSE OF MENTAL HEALTH OR DRUG OR ALCOHOL ABUSE CARE AND TREATMENT SHALL BE ENTITLED TO PERSONAL ACCESS TO HIS OR HER MENTAL HEALTH OR DRUG OR ALCOHOL ABUSE TREATMENT INFORMATION, EXCEPT THE FOLLOWING:"

"INFORMATION THE PERSON IN CHARGE OF THE CARE AND TREATMENT OF THE PATIENT DETERMINES TO BE REASONABLY LIKELY TO ENDANGER THE LIFE OR PHYSICAL SAFETY OF THE PATIENT OR ANOTHER PERSON" AND/OR "INFORMATION REQUESTED BY AN INMATE THAT A CORRECTIONAL INSTITUTION HAS DETERMINED MAY JEOPARDIZE THE HEALTH, SAFETY, SECURITY, CUSTODY OR REHABILITATION OF THE INMATE OR OTHER PERSON."

By signing the previous page, you acknowledge all of the following.

- I may revoke this Authorization at any time by providing my written revocation to the facility Correctional Health Services Administrator or the Health Services Division of ODOC at 3300 Martin Luther King Avenue, Oklahoma City, OK 73111.
- Revoking authorization will not apply to information already disclosed in response to this Authorization. Unless sooner revoked or an expiration is not designated the automatic expiration date of this Authorization will be twelve (12) months from the date of signature.
- ODOC may not condition the provision of treatment or payment for my care on my signing this Authorization.
- Information disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- The information authorized for release may include drug/alcohol use treatment records. This category of medical information/records is protected by federal regulations (Confidentiality of Substance Use and Disorder Patient Records 42 CFR Part 2). The Federal regulations prohibit anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below, I specifically authorize any such records included in the healthcare records to be released.
- DOC has the ability to deny/limit records requested by or for an inmate, if DOC determines the inmate having access to the records would jeopardize the health, safety, security, custody, or rehabilitation of the inmate or other inmates or the safety of an officer, employee, or other person at the correctional facility or responsible for the transporting of the inmate. 45 C.F.R § 164.524; 43A O.S. § 1-109.
- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE.**

_____	_____	_____
Signature of Individual/Patient or Authorized Legal Representative**	**If not Individual/Patient above, state the relationship to Individual/Patient**	**Date**