To prevent delay of processing your request, please include a copy of a government issued photo ID (i.e. a driver's license) for verification of signature.

Shadow Mountain Behavioral Health System

6262 South Sheridan, Tulsa, Oklahoma 74133

Authorization to Use or Disclose Protected Health Information

Patient Name: _____

Date of Birth: _____ SSN: _____

Dates of Treatment: _____

I hereby freely and voluntarily authorize Shadow Mountain Behavioral Health System to:

_____Release/ disclose my protected health information to: Email _____

Individual, Facility, or Organization | Phone Number | Fax Number

Address | City | State | Zip

The purpose of this disclosure is for:

___Insurance purposes ___Educational placement ___Legal reasons
___Medical treatment ___Discharge planning ___Continued treatment
___Progress updates ___The patient ___Other_____

Information to be used or disclosed:

___Dr's Discharge Summary ___Psychiatric Evaluation ___Mental Status ___History & Physical
___Psychological Testing ___Treatment Plans ___Lab/X-ray results ___Progress Reports
___Psychological Assessment ___Immunization status ___Physician Orders ___Substance Abuse Tx
___Aftercare Plan ___Discharge Instructions ___Other_____

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NONCOMMUNICABLE DISEASE, or related to mental health, testing, drug, substance, and/or alcohol diagnosis and treatment. I understand that such information is confidential and is protected by federal law. I understand that the provision of health care treatment to me cannot be conditioned upon my agreement to sign an authorization for the disclosure or use of my health information for purposes other than for treatment, payment, and healthcare operations. I understand that the potential exists for health information that is released with my authorization to be re-disclosed by the recipient, and to be no longer protected by the Federal HIPAA law. I understand that I have the right to revoke this authorization at any time by giving written notice to Shadow Mountain and/or other facility privacy officer, except to the extent that action has already been taken in reliance on it. The authorization will expire 180 days following discharge, or following signature date unless another date or condition is specified. Other date or condition specified:

SIGNATURES

Patient – When applicable by law or hospital policy | Date

Guardian or Representative | Relationship to Patient | Date

Witness | Date

***Drug and alcohol records are protected by Federal confidentiality ruling (42 CFR part 2)** and require written consent to disclose this information unless otherwise permitted by 42 CFR part 2. Further disclosure is prohibited without written consent by the person to whom the information pertains unless otherwise permitted by the law. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

****Psychiatric Records:** Oklahoma State Law (760.S. Supp. 1986 Section 19) Provides that psychological or psychiatric records may be provided to a patient only if the treating practitioner consents to the release, or upon a court order issued by a court of competent jurisdication.

Shadow Mountain Behavioral Health System is now closed as of June, 2019
Custodian of Records for closed facilities:
Universal Health Services-Nashville Regional Office
1000 Health Park Dr. Bldg. 3 Ste. 300, Brentwood, TN 37027
Phone: 615-312-5834 Fax: 615-997-1200 Email: nrorecordsrequests@uhsinc.com