## **Underground Vaults & Storage, Inc.**

5621 West Reno Ave., Suite D Oklahoma City, OK 73127-6632 Fax: 405-947-0816

## AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION Pursuant to 45 C.F.R. 164.508

	Name of Health Care Provider/Physician/Facility/Medicare or Medicaid Contractor			
	Street Address	City	State Zip Code	
Re:	Patient Name: Date of Birth:	Social Security No:		
descriunder information such particular language description and the such particular language description and t	ibed herein. I understand that estand that, if the person(s) of mation are not subject to federal person(s) or organization(s) mageby authorize Underground Vau	s the disclosure of the Patient's properties authorization is voluntary and more organization(s) that I authorize to all and state health information privacy y not be protected by those laws.  The state of the Patient's properties and the protection of the protect	nade to confirm my direction. It is receive my protected health laws, subsequent disclosure by apployees, as the custodian of my	
	e(s)			
Organ	nization(s)			
Addre	ess(es)			
1.	required) including, but not inpatient, outpatient and en notes, nurses notes, clinical results, correspondence, rec	than psychotherapy notes for whit limited to, office notes, history armergency treatment, clinical charts, records, treatment plans, admission ords received from other medical prong to the Patient's care and treatment.	nd physical, consultation notes reports, order sheets, progress records, discharge records, test viders and all other information	

2.	Specific description of the purpose for each use or disclosure (or write "At the request of the individual" in this space):	
3.	I understand that I may revoke this authorization in writing at any time by sending a signed and dated written statement to Underground Vaults & Storage, Inc., stating that I am revoking mathematical authorization to disclose health records, except to the extent protected health information has been released in reliance on this authorization. I further understand that my eligibility for health benefits, my enrollment in a health plan, and my treatment will not be affected by whether or not I sign this authorization.	
4.	Unless sooner revoked, this authorization expires on the date one year subsequent to the date this Authorization. This Authorization is given in compliance with the consent requirements f release of alcohol or substance abuse records of 42 CFR 2.31, the restrictions of which have beconsidered and expressly waived.	
	e had the opportunity to read and consider the contents of this authorization and confirm that the nts are consistent with my direction.	
	Dated:	
Patie	nt or Legal Representative Signature (See 45 CFR 164.508(c)(1)(vi)	
•	esentative's Relationship to Patient  CFR 164.508(c)(1)(iv)	
Printe	ed Name:	
Addro	ess:	
Telep	bhone:Email:	
Other	* Contact Information	
Notes	<b>5:</b>	
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<sup>1.</sup> Protected health information ("PHI") is health information that is created or received by a health care provider, health plan, or health care clearinghouse which relates to: 1) the past, present, or future physical or mental health of an individual; 2) the provision of health care to an individual; or 3) the past, present, or future payment for the provision of health care to an individual. To be protected, the information must be that it identifies the individual or provides a reasonable basis to believe that the information can identify the individual. 45 C.F.R. 164.508

<sup>2.</sup> These laws apply to health plans, health care providers, and health care clearinghouses.