



DELAWARE NATION VOCATIONAL REHABILITATION PROGRAM



AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

I. INDIVIDUAL INFORMATION (FOR PERSON WHOSE INFORMATION WILL BE SHARED)

Name	Date of Birth	
Address	City	
State	Zip	Area Code & Telephone Number

II. SCOPE & PURPOSE FOR SHARING INFORMATION

I understand protected health information is information that identifies me. The purpose of this authorization is to allow _____ to share my protected health information.

If this box is checked, I authorize the Delaware Nation Vocational Rehabilitation Program to share my PHI with the Delaware Nation Executive Committee, as needed, for complaint investigation and administration of the program. I understand this authorization is optional, and other steps must be taken to resolve a complaint prior to the Executive Committee's involvement. Further, I understand sharing of information with the Executive Committee may include information about my disability, services requested or received and other personal information included in my case file.

_____ _____
Initials Date

III. AUTHORIZATION & INFORMATION TO BE SHARED

I authorize _____ as set forth below, to share my protected health information for reasons in addition to those already permitted by law.

A. Persons/Organizations receiving information and purpose for sharing (Name, Address, Phone, & Fax. Include Patient ID #, if applicable.)

Relationship

B. Information to be shared

1. Specific Information to be shared (check one or more boxes below).

- Medical Psychological Vocational
 Other (specify) _____

2. The purpose and need for such disclosure:

- Establish eligibility for rehabilitation services
 Develop a vocational plan for client
 Determine need for and/or type of treatment

3. The information I authorize may include information that could be considered information about communicable or non-communicable which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS) (Statute 63 O.S. 1-502-2[B]). I understand that information in my records that I have a communicable or non-communicable disease is made confidential by law and cannot be released without my permission except in limited circumstance including release to persons who have had risk of exposures. When such information is released it cannot contain information from which I can be identified unless release of that identifying information is authorized by me, by an officer of the court or the Department of Health by law. I understand that these records may include psychiatric, alcohol and drug abuse information, occupational information or information regarding other insurance coverage.



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IV. EXPIRATION & REVOCATION

A. This authorization will expire (must choose one):

- 12 months from the date signed in Part V.
- Other (insert date or event): _____

B. Right to revoke

I understand I may change this authorization at any time by submitting a written request to the Delaware Nation Vocational Rehabilitation Program Coordinator. I understand I cannot restrict information that may have already been shared based on this authorization.

V. SIGNATURES

This document must be signed by the individual's legal representative.

Signature (Patient or Legal Representative)	Date
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Printed Patient or Legal Representative Name	Capacity of Legal Representative (if applicable)
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