Dr. Kathryn S. Young, M.D., F.A.A.P

(Former Clinical Office address: 3400 NW Expressway Suite #830 Oklahoma City, Oklahoma 73112)
Contact Info: for Records FAX (405) 337-9635 email kathrynyoung@cox.net **DO NOT SEND PHI VIA EMAIL**

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: ______________________________________ DOB: __________________

Please Send Information To:

Name of Provider: ____

Provider Address: ____

Provider Phone: (_____) ______-_________

Provider email _________________________________

Please Send Records From:

Provider: Dr. Kathryn S. Young, M.D., F.A.A.P

Former Clinical Address: 3400 NW Expressway Suite #830 Oklahoma City, Oklahoma 73112

____ (REQUIRED initials to acknowledge) Provider is retired from clinical practice. Records are made available on a best-efforts basis by authorized volunteers. No time frame for response is expressed or implied or accepted by this request

I authorize the following information to be disclosed:

☑ Complete Medical Record

☐ Other ____

RECORDS TO BE PROVIDED VIA (REQUIRED check one)

☐ Email to ____ via a secure email service

☐ Encrypted Thumb Drive to be provided by the requesting party.
Contact information person responsible for receiving instructions regarding encrypted Thumb Drive
Phone ____ _____ ________ __ email: _______________ Responsible Party Name ______________________________

ADDITIONAL PATIENT INFORMATION:

- I understand that my refusal to sign this authorization in no way affects my treatment, payment or eligibility for benefits.
- If the person or organization receiving this information is not a health care provider or health plan covered by federal health privacy laws, they may re-disclose any and all information authorized by this release and federal law would no longer protect it.
- This authorization can be revoked at any time, in writing, except to the extent that disclosure made in good faith has already occurred in reliance on this authorization. To cancel this authorization, send a written request to Dr. Kathryn S. Young, M.D. P.C.
- I understand that THE INFORMATION AUTHORIZED FOR RELEASE MAY CONTAIN INFORMATION WHICH MAY BE CONSIDERED A COMMUNICABLE, NON-COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, OR THE HUMAN IMMUNODEFICENCY VIRUS (HIV), ALSO KNOW AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS), DRUG OR ALCOHOL ABUSE, DRUG RELATE CONDITIONS, ALCOHOLISM CONDITIONS UNLESS SPECIFICALLY EXCLUDED.
- I understand that I have the right to restrict disclosure of my PHI to a health plan, if the disclosure is for payment or healthcare operations and pertains to a healthcare item or service for which I have paid out-of-pocket in full. I have the right to an accounting of disclosures of any and all breach notification of my unsecured PHI upon my written request to the Kathryn S Young, M.D. P.C. Privacy Officer. I also understand I have the right to "opt-out" of receiving communications from my provider should I choose to do so as long as I provide them with the request in writing.

Please exclude the following information if it is a part of my Medical Record Information (*indicate by initials any or all you want excluded from this authorization, use or disclosure)*: Any item not indicated by my initials is specifically authorized.

☐ Chemical Dependency/Substance abuse ☐ Sexually Transmitted Disease ☐ Alcohol ☐ Drugs ☐ Other (describe): ______________________

With this knowledge, I authorize the use or disclosure of the information identified above and release Dr. Kathryn S. Young, M.D., its affiliates, agents, and employees from liability in connection with the release of the information contained therein.

☒ ____ ___________________ _____/_____/____

Patient signature **(PARENT OR LEGAL REPRESENTATIVE, IF APPLICABLE)** **RELATIONSHIP** **DATE**