P.O. Box 722767 • Norman, OK 73070 • (405) 733-ALLY or 877-730-ALLY

# Consent for Release of Protected Health Information

This form must accompany the Application for Financial Assistance for Ally's House to provide assistance.

## Section 1 – Patient/Guardian Release

**I, ________________________ (Circle) Patient, Parent, Guardian, legal custodian of:**

**__________________________ SSN: _____-____-_____ DOB: ______/______/__________**
**(NAME OF PATIENT)**

**Authorize the physicians and staff of the facility or medical practice treating this patient to release to:**
**Ally's House, Inc., P.O. Box 722767, Norman, OK 73070**

All of the following medical information regarding this patient:

- ☐ Lab Reports
- ☐ Billing Records
- ☐ Radiology Reports
- ☐ Medical List/Invoice
- ☐ Reports of Treatment/Diagnosis
- ☐ Medications/Prescriptions
- ☐ The following other information or documents: ______________________________

Treatment dates to be included in disclosure:

___/___/___ TO ___/___/___

Method by which information is to be released:

- ☐ Mail
- ☐ Fax
- ☐ Verbal Exchange
- ☐ Other: ______________________________________
______________________________________________

**Information is being released for the following purpose:** To qualify for an award/contribution from Ally's House, Inc. a not for profit organization.

**Date, Event, or Condition when Consent Expires: Continuing Consent**
In the event no date, event, or condition is specified for expiration, this consent expires in ninety (90) days from the date of signing.

I understand that treatment services are NOT contingent upon or influenced by my decision to permit the information release. I also understand that I may revoke this consent in writing at any time unless action has already been taken based upon it. I freely and voluntarily give this consent.

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law.

**THE INFORMATION I AUTHORIZE FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOW AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).**

| X | | X | |
|---|---|---|---|
| Signature of consumer, parent, guardian or authorized legal representative when required | Date | Witness (Optional) | Date |

Description of Legal Representative's Authority, if applicable.

## Section 2 – Physician Certification

I certify that that the patient listed in this application is ***currently receiving treatment*** from the: *(check one)*

- ☐ Jimmy Everest Center, OU Physicians or OU Medical Center/Children's Hospital; or
- ☐ St. Francis Hospital; or
- ☐ ________________________________________ for a form of cancer.
  **(name of hospital or treatment facility)**

______________________________ ______________________

**Physician Signature** **Date**