

Oklahoma Horsemen's Benevolent & Protective Association

Authorization for Use and Disclosure of Protected Health Information

Please fill out highlighted areas only

Name _____ Date _____

Birth Date _____ SSN _____

Account/Health Record Number _____

I authorize **Oklahoma Horsemen's Benevolent & Protective Association, dba TRAO**
1 Remington Pl, Oklahoma City, OK 73111 to receive my free copy of the information from:

The following individually identifiable health information may be used and/or disclosed:

Check all that apply:

<input checked="" type="checkbox"/> Discharge Summary	<input checked="" type="checkbox"/> Reports of Lab Test
<input checked="" type="checkbox"/> History and Physical Records	<input checked="" type="checkbox"/> Reports of X-Rays
<input checked="" type="checkbox"/> Face Sheet	<input checked="" type="checkbox"/> Emergency Room Records
<input checked="" type="checkbox"/> Consultation Reports	<input checked="" type="checkbox"/> Operative Reports
<input checked="" type="checkbox"/> Pathology Reports	<input checked="" type="checkbox"/> Payment/Billing Records
<input checked="" type="checkbox"/> Psychotherapy Notes	<input checked="" type="checkbox"/> Other _____

Dates of treatment to be released _____

The above mentioned health record is being requested to process my request for assistance with incurred charges.

I authorize the release of any information contained in the above records concerning treatment of drug or alcohol abuse, drug related conditions, alcoholism, psychiatric/psychological conditions, psychiatric/mental health treatment and/or HIV related conditions.

I understand that I have the right to revoke this Authorization, if the revocation is in writing and delivered to the **Oklahoma Horsemen's Benevolent & Protective Association**. Any revocation will have no effect on any action taken by the **Oklahoma Horsemen's Benevolent & Protective Association** in reliance upon this Authorization and prior to receiving any revocation.

By signing this Authorization, I acknowledge that I have read and understand this Authorization; I authorize the use and disclosure of my health information and in accordance with the terms of this Authorization. Further, I give authorization for any health information records to be sent to the **Oklahoma Horsemen's Benevolent & Protective Association** via fax.

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Signature of Individual or Personal Representative _____ Date _____

This authorization expires on December 31, 2026

Phone: (405) 427-8753

Fax: (405) 427-7099