Authorization For OU Health to RELEASE Health Information/Treatment Records

Patient Information:

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment:			
Date of Birth (MM/DD/YYYY)	Home/Cell Phone:	Work Phone:	
Street Address:	City:	State:	Zip:

The Records I Request Access to or a Copy of are:

Date(s) of service: _____/___/_____through _____/___/____

Location (Facility/Phys Office Name):_____

Purpose of Request:	□ Referral	□ Legal	□ Transfer	□ Other

***My Chart Portal: Download your records through My Chart:** https://mychart.ouhealth.com

Check requested records:

□ Provider Records (H&P, Progress Notes, OP Notes, DC Summary, Consults)
□ X-ray Reports □ Imaging/Rad Films □ Immunization Records □ Discharge Summaries
□ EKG/ECG □ Mammogram Reports □ Orders □ ER Records □ Lab Reports
□ Fetal/Newborn Monitoring □ Billing Records □ Itemized Bill
□ Other: _____
□ Entire Health Record + Billing Records
□ Psychotherapy Note*
*If checked, no other boxes may be checked. Use a separate form to request any other record types.

OU Health should provide my records to:	□ Self	□ Person/Organization Specified Below
Recipient Name of person or Organization:		
Recipient Address:		
Recipient Fax:	Recipient Phone:	

How do you prefer your records delivered?

□ Pickup □ Mail □ Fax □ Email

Email Delivery Consent

_____ I understand email is not secure, may include sensitive health information, and I want my records sent by email.

I will notify OU Health if the email address changes.

Email address: _____ @_____

I Understand:

- I may cancel this authorization at any time in writing. This will not apply to information already released. This authorization expires in ___ months or after 12 months if left blank.
- I understand that information released may be re-disclosed by the recipient and may no longer be protected by federal privacy laws.
- I understand fees may apply for copies of records in accordance with Oklahoma and federal law, and payment may be required before release.
- I confirm this request is not for any prohibited purpose under HIPAA, including investigations or actions related to lawful reproductive health care.

_____ I understand this may include substance use disorder records protected under federal law (42 CFR Part 2). **By initialing, I specifically authorize release of these records**. I understand these records cannot be re-disclosed without my written permission unless allowed by law.

Signature of Patient, Parent, or Person Authorized to Sign on Patient's Behalf **Relationship to Patient** **Date**

*May be requested to show proof of representative status

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