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| ou-logo | | |  | | | | | | | | | | | | | |  | | | | | | | | | | | | | | |
| **Authorization to Release/Request for an Individual’s Health Information/Treatment and Education Records** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Last Name: | |  | | | | | | | | First: | | | | |  | | | | | | Middle: | | | | | |  | | | | |
| Other Names Used: | | | | |  | | | | | Date of Birth: | | | | | | | |  | | | | | | | | | | | | | |
| Address: |  | | | | | | | | | City: | | | | |  | | | | | State: | | |  | | | | | | Zip: | |  |
| Home Phone: | | | | ( ) | | | Alt. Phone: | | | | | | | | ( ) | | | | | Cell Phone: | | | | | | ( ) | | | | | |
| If currently enrolled OU student, enrollment dates: | | | | | | | | |  | | | | | | | | | | to |  | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I request access to the following protected health information from my health record or, if I am a student, my treatment/education record from, (date)       to (date)       maintained or created by the provider named below to the recipient named below. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Entire Health Record  (Excludes Billing Records/Notes and Psychotherapy Notes\*) | | | | | | | | | | | | | | | | Or only these portions of my record: | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | Billing Records | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | X-ray Reports/Films | | | | | | | | | | | | | | | |
| Entire Health Record **\***  (Includes Billing Records/Notes)  (Excludes Psychotherapy Notes\*) | | | | | | | | | | | | | | | | Immunization Records | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | Discharge Summaries | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | Most Recent Progress Notes | | | | | | | | | | | | | | | |
| Psychotherapy Notes\* (if checking this box, no other boxes may be checked. A separate copy of this form must be completed to obtain additional records.) | | | | | | | | | | | | | | | | Pathology/Lab Reports | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| I will pick up copies of my records when called | | | | | | | | | | | | | | | | Mail copies of my records to the recipient below | | | | | | | | | | | | | | | |
| Fax my records to: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | Other requested format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | |  | | | | | | | | | | | | | | | |
| **Release Records From:** | | | | | | | | | | | | | | | | **Provide Records To:** | | | | | | | | | | | | | | | |
| Name: | | | | | | | | | | | | | | | | Name: | | | | | | | | | | | | | | | |
| Address: | | | | | | | | | | | | | | | | Address: | | | | | | | | | | | | | | | |
| City: | | | | | | State: | | Zip: | | | | | | | | City: | | | | | | State: | | | | | | | | Zip: | |
| Fax: | | | | | | Phone: | | | | | | | | | | Fax: | | | | | | Phone: | | | | | | | | | |
| Purpose of Request:  patient’s / parent’s / authorized legal representative’s\*\* request  dispute  referral  legal  other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **I understand:** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * I may revoke this Authorization at any time by providing my written revocation to the address at the bottom of this form. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. Unless sooner revoked, the automatic expiration date of this Authorization will be twelve (12) months from the date of signature. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| * Unless the purpose of this Authorization is to determine payment of a claim or benefits, OU may not condition the provision of treatment or payment for my care on my signing this Authorization. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * For non-students, information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations. Student treatment/education records may retain continuing privacy protections in accordance with 34 CFR Part 99 (FERPA). | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
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| * **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE.** | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * \*The information authorized for release may include information related to mental health. Release of mental health records or psychotherapy notes may require consent of the treating provider or a court order. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * The information authorized for release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below, I specifically authorize any such records included in my health information to be released. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| * I agree that costs for records are as follows and are payable prior to the release of the requested records:   Paper Format – 50 cents per page, plus postage  Digital Format – 30 cents per page plus the cost of the digital media (disk, flash drive, etc.), plus postage  X-ray Film - $5 per x-ray/film, plus postage  (Releases in response to subpoenas or requests by attorneys and insurance companies are charged an additional $10 fee.)  Make checks payable to the University of Oklahoma. These fees were set by the Oklahoma legislature. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | |  | | |  | | | | | | | | | | |  | | |  | | | |
| **Signature of Patient, Parent, or Authorized Legal Representative\*\*** | | | | | | | | | | | |  | **Relationship to Patient** | | | | | | | | | | |  | | | **Date** | | | | |

**\*\*May be requested to show proof of representative status**

University of Oklahoma Health Sciences Center, University Privacy Official, P. O. Box 26901, Oklahoma City, OK 73129