OU Physicians	**Adult Medical Records** 825 NE 10th St, Suite 4600 Oklahoma City, OK 73104 P: (405)271-9194 **F: (405) 271-9195**	OU Children's Physicians	**Children's Medical Records** 940 NE 13th Street, 1B1301 Oklahoma City, OK 73104 P: (405) 271-2374 **F: (405) 271-2341**

Request for an Individual's Health Information

Last: **First:** **Middle:**

Other Names Used: **Date of Birth:** **SS#:**

Address:

Home Phone: ( ) **Work Phone: ( )**

☐ I hereby request access to the protected health information in my health record from (date) _____ to (date) _____ maintained or created by the following providers associated with the University of Oklahoma listed below.

[ ] Most recent Progress Note
[ ] Pathology/Lab Reports
[ ] X-rays Reports
[ ] Billing Records
[ ] Immunization Records
[ ] Entire Health Record
[ ] Other_____

[ ] I will pick up the copies of my records
[ ] Mail copies of my records to the individual noted below :

Records From:	Records To:
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

Purpose of Request: __patient's request, __dispute, __referral, __other: _____

I understand:

- I may revoke this authorization at any time by providing my written revocation to: OU Physicians Medical Records Department, 825 NE 10th, Suite 4600, Oklahoma City, OK 73104. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be six (6) months from the date of signature.
- Unless the purpose of this authorization is to determine payment of a claim or benefits, OU Physicians and/or OU Children's Physicians may not condition the provision of treatment or payment for my care on my signing this authorization.
- Information used or disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE.**
- The information authorized for release also may include protected health information related to mental health.
- The information authorized for release also 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 records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as 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 understand that if my records are released from OU Physicians that I will be charged $1.00 for the first page and $0.50 for each subsequent page for paper records and $5.00 per film for radiology film, plus postage payable prior to the release of the requested records. (Make all checks payable to OU Physicians). **These fees have been set by the Oklahoma state legislature.**

_____ _____ _____

Signature of Patient, Parent, or Legally Authorized Representative | Relationship to Patient | Date