
	<b>Adult Medical Records</b> 825 N.E. 10 <sup>th</sup> St, Suite 4600 Oklahoma City, OK 73104 P: (405) 271-9194 F: (405) 271-9195		<b>Children's Medical Records</b> 4500 N. Phillips Ave Suite B770 Oklahoma City, OK 73104 P: (405) 271-2374 F: (405) 271-2341
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**Authorization to Release/Request for an Individual's Health Information**

**Last Name:** \_\_\_\_\_ **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 covering the period from (date) \_\_\_\_\_ to (date) \_\_\_\_\_ maintained or created by the provider associated with the University of Oklahoma listed below.

- |   |  |
|---|--|
| <input type="checkbox"/> Most recent Progress Notes | <input type="checkbox"/> Immunization Records  |
| <input type="checkbox"/> Pathology/Lab Reports      | <input type="checkbox"/> Entire Health Record (Excludes Psychotherapy Notes)   |
| <input type="checkbox"/> X-ray Reports/Films        | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Discharge Summaries        | <input type="checkbox"/> Mental Health Records (if checking this box, no other boxes may be checked). A separate Authorization to Release/Request for an Individual's Health Information must be completed.* |
| <input type="checkbox"/> Billing Records            |  |

- I will pick up 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 the address at the top of this form. 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 twelve (12) months from the date of signature.
- 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.
- 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 protected health information related to mental health.
- 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 understand that if my records are released, I will be charged \$1.00 for the first page, \$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 Fill in the blank ). These fees have been set by the Oklahoma legislature.

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**Signature of Patient, Parent, or Legal Authorized Representative\***      **Relationship to Patient**      **Date**

\*May be requested to show proof of representative status