*Also needed to Authorize grand parents, when legal guardians/parents unavailable

The University of Oklahoma

Authorization to Release Protected Health Information **Verbally** to Others

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 _____ give my permission to: _____
Name of Physician, Provider, and/or Department/Clinic

to release **verbally** information regarding appointment dates/times and my protected health information checked below created from (date) _____ to (date) _____, maintained or created by the Provider or Clinic named above to the Recipient(s) named below.

Verbally Release the Above Information to:					
Recipient Name:			Recipient Name:		
Relationship to Patient:			Relationship to Patient:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Fax:	Phone:		Fax:	Phone:	
Exceptions:			Exceptions:		

This authorization to release Protected Health Information **verbally** applies to discussions about information from my:

☐ Entire Health Record*
(Excludes Billing Records/Notes and Psychotherapy Notes)

☐ Entire Health Record plus Billing Records/Notes*
(Excludes Psychotherapy Notes*)

☐ Psychotherapy Notes* (if checking this box, no other boxes may be checked. A separate copy of this form must be completed to obtain any other types of records.)

Or only information from these portions of my record:

☐ Billing Records
☐ X-ray Reports
☐ Immunization Information
☐ Discharge Summaries
☐ Most Recent Progress Notes
☐ Pathology/Lab Reports
☐ Other_____

Purpose of Request: ☐ patient'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 clinic named in the upper left-hand corner or the University Privacy Official at University of Oklahoma Health Sciences Center, P.O. Box 26901, Oklahoma City, OK 473126-0901. 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.
- 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).
- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE.**
- *The information authorized for verbal 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 verbal 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.

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

**May be requested to show proof of representative status

File in Patient Chart

HIPAA Document
Retain for a minimum of 6 years