REGISTRATION

NAME

ADDRESS

CITY STATE ZIP CODE

HOME PHONE WORK PHONE CELL PHONE

DATE OF BIRTH GENDER: ____Male_____Female

MARITAL STATUS RACE

EMERGENCY CONTACT

EMERGENCY CONTACT PHONE#

PRIMARY CARE PHYSICIAN

PRIMARY CARE PHYSICIAN PHONE#

AUTHORIZATION AND CONSENT
OU Physicians - Tulsa

Patient Name:			MRN:
_____ Last Name	_____ First Name	_____ Middle Name	Date of Birth:

Recognizing the need for medical care for the patient whose name appears on this form, I voluntarily consent to care encompassing routine diagnostic procedures and medical treatment by OU Physicians–Tulsa and their assistants or designees as is necessary. I understand, other than in the case of emergency treatment, I will have the opportunity to participate in the decision making process about the patient's care. I understand that if any non-routine procedures or treatments are required, I will be asked to sign separate consent forms for that treatment. I understand the practice of medicine is not an exact science and no guarantees have been made as to the result of the examination or medical treatment by OU Physicians-Tulsa.

I understand OU Physicians–Tulsa has teaching responsibilities through its affiliation with the University of Oklahoma and give my permission for the involvement of health care students, residents and other medical personnel for educational purposes.

I authorize OU-Physicians to access current and previous information regarding my prescription medication information. I understand that if I do not grant or choose to revoke this access, OU-Physicians may terminate the patient from the OU-Physicians Tulsa group practice.

I authorize OU Physicians – Tulsa to furnish requested information or excerpts from the patient's record to any insurance company (including Medicare and Medicaid), health plan or sponsoring agency that may be providing financial assistance for medical care. This may include agents or review agencies necessary for processing any claim, for obtaining payment; and to any physician, hospital, laboratory, radiological facility or other health care provider to which the patient has been referred or is necessary to support continuity of care. I understand that these medical records may include all information relative to the patient's physical condition, past and present, including the diagnosis and history of the patient's case, psychiatric history and alcohol or drug abuse information.

I understand that OU Physicians - Tulsa may use this information as described under the Notice of Privacy Practices for the University of Oklahoma. I acknowledge that I have received a copy of the University's Notice of Privacy Practices and I consent to the use of my Protected Health Information for treatment, payment and the healthcare operations of the University as summarized in the Notice of Privacy Practices and according to applicable federal and state laws.

I understand that if I am an OU student seeking student health services or treatment, I consent to the release of my treatment / education records for payment for services rendered to my insurance carrier or payer and authorize the carrier or payer to pay OU for services rendered.

I authorize payment of medical benefits to OU Physicians – Tulsa for services provided to the patient. I also authorize payment of government benefits to OU Physicians – Tulsa. This assignment remains effective until I revoke it in writing. I understand that I am obligated to provide information to OU Physicians – Tulsa about any medical or health insurance benefits the patient may have. I understand that medical insurance does not relieve me of financial responsibility to OU Physicians – Tulsa and I accept full responsibility for services rendered that are not covered by government or insurance benefits. I understand that I am responsible for obtaining all referrals or authorizations required by my insurance.

Patient Name:			MRN:
_____ Last Name	_____ First Name	_____ Middle Name	Date of Birth:

I understand that mental health records are maintained in the electronic medical records system. If I seek mental health treatment from OU Physicians – Tulsa. I understand that records related to that treatment will be in the electronic medical records system, which is accessible by OU Physicians – Tulsa providers and staff.

I understand that photographs, videotapes, digital, or other images may be recorded to document the patient's care, I understand that OU Physicians–Tulsa will retain the ownership rights to these photographs, videotapes, digital, or other images, but that I may be allowed access to view them or obtain copies. I understand that these images will be stored in a secure manner and that they will be kept for the time period required by law or necessary for my treatment, whichever is longer. Images that identify me will be released and/or used outside the institution only upon written Authorization from me or my legal representative or as provided by law.

I understand patients who are less than 18 years of age (unless they have legal rights to self-consent) or incapacitated adults must be accompanied by a parent, legal guardian or authorized person in order to receive medical care. I authorize the following individuals to consent to medical care for this patient:

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

MY SIGNATURE BELOW ACKNOWLEDGES THAT I AM THE PATIENT, THE PATIENT'S PARENT, or LEGAL GUARDIAN, I HAVE READ AND UNDERSTAND THE CONTENTS OF THIS DOCUMENT AND I AM LEGALLY AUTHORIZED TO SIGN THIS FORM.

Patient's Full Legal Name (PRINT):	Date of Birth:
Relationship to patient: ___Self ___Parent ___*Health Care Proxy (attach copy of Advance Directive)* ___*Legal Guardian (attach copy of court appointed guardianship)* ___*Durable Health Care Power of Attorney (attach copy of Health Care Power of Attorney)* ***Witness: Initial here when the required documents in italics are received**:_____*	

Signature:	Printed Name:	Date:
Witness Signature:	Printed Name:	

Persons who are *Health Care Proxy, Legal Guardians or Durable Health Care Power of Attorney* MUST provide required documentation before signing this consent and before the patient is seen.

Physicians
THE UNIVERSITY OF OKLAHOMA
HEALTH CLINIC AT RSU

Rogers State University
1701 W. Will Rogers Blvd.
Claremore, OK 74017-3252

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: _____
Home Phone: ( ) _____ **Work Phone:** ( ) _____
Check here if you are an enrolled RSU student____

I hereby request access to the protected health information in 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.
If applicable, the student's dates of enrollment are _____ to _____.

- ☐ Most recent Progress Notes
- ☐ Pathology/Lab Reports
- ☐ X-ray Reports/Films
- ☐ Discharge Summaries
- ☐ Billing Records
- X Drug Test Reports
- X Physical Exam Completion
- X Immunization Records
- ☐ Entire Health Record *(Excludes Psychotherapy Notes)
- X Other - TB Skin Test Expiration Date
- ☐ Psychotherapy Notes* (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 to obtain additional records.)

- ☐ I will pick up copies of my records
- ☐ Fax my records to: _____
- ☐ Mail copies of my records to the individual noted below
- ☐ Provide my records in electronic form: _____

Records From:		Records To:	
Name:	OU Physicians Clinic at RSU	Name:	RSU Health Science Department
Address:	1701 W. Will Rogers Blvd.	Address:	1701 W. Will Rogers Blvd.
Phone:	918-343-7614	Phone:	918-343-7631
Fax:	918-343-7802	Fax:	918-343-7628

Purpose of Request: ☐ patient's request, ☐ dispute, ☐ referral, X other: to confirm clinical rotation requirements are met

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 sooner revoked, the automatic expiration date of this Authorization will be upon the date of graduation or withdrawal from Rogers State University.
- 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 and/or student treatment/education records 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 (initial one):
  ____ 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 Legal Authorized Representative** **Relationship to Patient** **Date**

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

The University of Oklahoma
OU Physicians Health Clinic at RSU

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the University of Oklahoma's ("OU") Notice of Privacy Practices ("Notice"):

- The Notice tells me how OU will use my health information for the purposes of my treatment, payment for my treatment, and OU's health care operations.
- The Notice explains in more detail how OU may use and share my health information for purposes other than treatment, payment, and health care operations.
- OU will also use and share my health information as required/permitted by law.
- If I am an OU student receiving student health services, I consent to OU using and disclosing my treatment and education records it maintains for the purposes detailed in OU's Notice of Privacy Practices.

Patient's Complete Legal Name: _____
(please print)

Patient's DOB _____ Date: _____

Signature: _____
(Patient or Legal Representative*)

*May be requested to show proof of representative status

UNIVERSITY OF OKLAHOMA
NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: April 14, 2003
LAST REVISED: June 15, 2016

This NOTICE describes how your medical information may be used and disclosed and how you can get access to that information. It applies to the health information that is protected by HIPAA, used to make decisions about your care, and generated or maintained by the University of Oklahoma (OU).

Please review it carefully.

OU is required by law to protect the privacy of your health information that is protected by HIPAA, give you a Notice of OU's legal duties and privacy practices, and follow the current Notice. It will be followed by all employees, students, and volunteers of the health care components of OU, which include, but are not limited to all or part of:

College of Allied Health
College of Dentistry
College of Medicine and
OU Physicians
College of Medicine – Tulsa and
OU Physicians – Tulsa
College of Nursing
College of Pharmacy
College of Public Health
Department of Athletics
OU Health Services - Goddard
School of Community Medicine
University Counseling Center - Goddard
Certain administrative offices
Certain operations offices

1. Uses and Disclosures of Your Health Information

The following describe some of the ways that OU may use or disclose your health information that is protected by HIPAA without your authorization.

Treatment: OU will use your health information to provide you with medical treatment/services and for treatment activities of other health care providers. *Examples:* Your health information may be used by doctors and students involved in your care. OU maintains medical information about its patients in an electronic medical record that allows OU to share medical information for treatment purposes. This facilitates access to medical information by other health care providers who provide care to you. OU may use an electronic prescribing gateway with pharmacies.

Payment: OU may use or share your health information for payment activities, such as to determine plan coverage, to bill/collect your account, or to help another health care provider with payment activities. *Example:* Your health information may be released to an insurance company to get pre-approval of or payment for services or to a collection agency if your account is not paid.

Operations: OU may use your health information for uses necessary to run its healthcare businesses, such as to conduct quality assessment activities, train, or arrange for legal services. *Example:* OU may use your health information to conduct internal audits to verify proper billing procedures.

Health Information Exchange: OU may participate in a health information exchange (HIE), an organization in which providers exchange patient information to facilitate health care, avoid duplication of services (such as tests), and reduce the likelihood of medical errors. By participating in an HIE, OU may share your health information with other providers who participate in the HIE or participants of other HIEs. If you do not want your medical information in the HIE, you must request a restriction using the process outlined below or by contacting the HIE.

Education: Education is part of OU's healthcare operations and treatment programs. OU may use and disclose your health information to faculty, staff, current and prospective students, volunteer and visiting faculty, and trainees and observers as part of its educational mission. *Example:* Your provider may discuss your case with students as part of a learning experience.

Business Associates: OU may disclose your health information to other entities that provide a service to OU or on OU's behalf that requires the release of your health information, such as a billing service, but only if OU has received satisfactory assurance that the other entity will protect your health information.

Individuals Involved in Your Care or Payment for Your Care: OU may release your health information to a friend, family member, or legal guardian who is involved in your care or who helps pay for your care.

Research: OU may use and disclose your health information to researchers for research. Your health information may be disclosed for research without your authorization if the authorization requirement has been waived or revised by a committee charged with making sure the disclosure will not pose a great risk to your privacy or that steps are being taken to protect your health information, to researchers to prepare for research under certain conditions, and to researchers who have signed an agreement promising to protect the information. Health information regarding deceased individuals can be released without authorization under certain circumstances.

Organ and Tissue Donation: If you are an organ or tissue donor, OU may release health information to donation banks or organizations that handle organ or tissue procurement or transplantation.

Fundraising/Marketing: OU may use (or release to an OU-related foundation) certain information such as your name, DOB, address, department of service, outcome, physician, insurance status, and treatment dates for fundraising. If you do not want to be contacted for fundraising efforts, notify OU's Privacy Official at the phone number or address in Paragraph 6 below. OU will not use your health information to contact you for marketing purposes or sell your health information without your written permission.

2. Uses and Disclosures of Health Information Required/Permitted By Law: The following describe some of the ways that OU may be allowed or required to use or disclose your health information that is protected by HIPAA without your authorization.

Required by Law/Law Enforcement: OU may use and disclose your health information if required by federal, state, or local law, such as for workers' compensation, and if requested by law enforcement officials for certain purposes such as to locate a suspect or in response to a court order.

Public Health and Safety: OU may use and disclose your health information to prevent a serious threat to the health and safety of you, others, or the public and for public health activities, such as to prevent injury. *Example:* Oklahoma law requires OU to report birth defects and cases of communicable disease.

Food & Drug Administration (FDA) and Health Oversight Agencies: OU may disclose health information about incidents related to food, supplements, product defects, or post-marketing surveillance to the FDA and manufacturers to enable product recalls, repairs, or replacements; and to health oversight agencies for

activities authorized by law, such as audits or investigations.

Lawsuits/Disputes: If you are involved in a lawsuit/dispute and have not waived the physician-patient privilege, OU may disclose your health information under a court/administrative order, or subpoena.

Coroners, Medical Examiners, and Funeral Directors: OU may release your health information to coroners, medical examiners, or funeral directors to enable them to carry out their duties.

National Security/Intelligence Activities and Protective Services: OU may release your health information to authorized national security agencies for the protection of certain persons or to conduct special investigations.

Military/Veterans: OU may disclose your health information to military authorities if you are an armed forces or reserve member.

Inmates: If you are an inmate of a correctional facility or are in the custody of law enforcement, OU may release your health information to a correctional facility or law enforcement official so they may provide your health care or protect the health and safety of you or others.

Oklahoma law requires that OU inform you that health information used or disclosed may indicate the presence of a communicable or noncommunicable disease. It may also include information related to mental health.

If OU wants to use and/or disclose your health information for a purpose not in this Notice or required or permitted by law, *OU must get specific authorization from you for that use and/or disclosure, and you may revoke it at any time by contacting the Privacy Official at the phone number or address in Paragraph 6.*

OU must obtain your authorization for most uses or disclosures of your psychotherapy notes. Some exceptions include use for Treatment by your provider or disclosures required by law.

3. Your Rights Regarding Your Health Information: You have the rights described below in regard to the health information that is protected by HIPAA that OU maintains about you. You must submit a written request to exercise any of these rights. Forms for this purpose are available at any of the locations where OU provides medical services. You also can get the forms by contacting the University's Privacy Official at the number or address in Paragraph 6 or at http://www.ouhsc.edu/hipaa/forms-patients.asp**.**

Right to Inspect/Copy: You have the right to inspect and get a copy of health information maintained by OU and used in decisions about your care. This right does not apply to psychotherapy notes and certain other information. By law, OU may charge for the copies and supplies, plus postage, payable prior to the release of the requested records. (Amounts are set by law.) OU may deny your request in certain circumstances. You may request a licensed health care professional chosen by OU to review a denial based on medical reasons; OU will comply with this decision.

Right to Amend: If you believe health information OU created is inaccurate or incomplete, you may ask OU to amend it. You must provide a reason for your request. OU cannot delete or destroy any information already included in your medical record. OU may deny your request if you ask to amend information that OU did not create (unless the creator is not available to make the amendment); that is not part of the health information OU maintains; that is not part of the information you are permitted by law to inspect and copy; or that is accurate and complete.

Right to Accounting of Disclosures: You have the right to ask for a list of disclosures OU has made of your health information. OU is not required to list all disclosures, such as those you authorized. *You must state a time period, which may not be longer than 6 years or include dates before April 14, 2003*. If you request more than one accounting in a 12-month period, OU may charge you for the cost involved. OU will tell you the cost; you may withdraw or change your request before the copy is made.

Right to Request Restrictions: You have the right to request a restriction or limit on how OU uses or discloses your health information. You must be specific in your request for restriction. You may restrict disclosure of your health information to a health plan only if the disclosure is for payment or health care operations and pertains to a Health Care item or Service for which you pay out-of-pocket in full at the time they are provided. OU is not required to agree to other requests. If OU agrees or is required to comply, OU will comply with the request unless the information is required to be disclosed by law or is needed in case of emergency. *Example*: You may want to pay cash in advance for services rather than have your insurance billed.

Right to Request Confidential Contacts: You have the right to request that OU contact you about medical issues in a certain way, such as by mail. You must specify how or where you wish to be contacted; OU will try to accommodate reasonable requests.

Right to a Copy of This Notice: You have the right to a paper or electronic copy of this Notice, which is posted and available at each location where medical services are provided and is on OU's website.

Right to Designate a Representative: If you have given someone a medical power of attorney or have a legal guardian, that person can exercise your rights under HIPAA and make choices about your health information. We may require proof of this person's status.

4. Changes to this Notice: OU reserves the right to change this Notice and to make the revised Notice effective for health information OU created or received about you prior to the revision, as well as to information it receives in the future. Revised Notices will be posted and available at each location where medical services are provided and on OU's website.

5. Right to be Notified. You have the right to be notified of breaches that may have compromised the privacy or security of your health information.

6. Information/Complaints. If you believe your privacy rights have been violated, you may file a complaint with OU's Privacy Official, Jill Bush Raines, at (405) 271-2511; 1-866-836-3150; OU Compliance@ouhsc.edu; or PO Box 26901, OKC, OK 73126-0901; or with the Secretary of the Department of Health and Human Services, Office of Civil Rights – DHHS, 1301 Young Street, Suite 1169, Dallas, TX 75202, (214) 767-4056; (214) 767-8940 TDD. Complaints must be submitted within 180 days of when you knew or should have known of the circumstance leading to the complaint. **You will not be retaliated against for filing a complaint.**

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

OU Office of Compliance
P O Box 26901
Oklahoma City, OK 73126-0901
Phone (405) 271-2511
Fax (405) 271-1076