Rogers State University
1701 Will Rogers Blvd.
Claremore, OK 74017

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 OU 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
- ☐ Immunization Records
- ☐ Entire Health Record *****(Excludes Psychotherapy Notes)
- ☐ Other_____
- ☐ 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:	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 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.
- **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**

Rev 10/2013 © 2011-2014