The University of Oklahoma
OU Physicians Reproductive Medicine

OU Physicians Reproductive Medicine
840 Research Parkway Suite 200
Oklahoma City, OK 73104

Authorization to Release Health Information/Treatment Records

Patient 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 request that the protected health information (or, if I am a student, my treatment/education record) checked below from, (date)_____ to (date) _____ maintained or created by the Provider named below be released to the Recipient named below.
- Initial here if your records may also be disclosed **verbally** to the recipient below:_____

☐ 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 these portions of my record:
☐ X-ray Reports/Films
☐ Immunization Records
☐ Discharge Summaries
☐ Medications
☐ Pathology/Lab Reports
☐ Billing Records
☐ Other: _____

*The information authorized for 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.

Release Records From Provider:			***Provide Records To Recipient:***		
Name:			Name: OU Physicians Reproductive Medicine		
Address:			Address: 840 Research Parkway, Suite 200		
City:	State:	Zip:	City: OKC	State:	Zip:73104
Fax:	Phone:		Fax: 405-271-9222	Phone: 405-271-1616	

Purpose of Request: ☐ patient's request ☐ dispute ☐ referral ☐ legal ☐ other:_____

I understand:

- I may revoke this Authorization at any time by providing my written revocation to the address at the bottom 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.
- 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 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 to the University of Oklahoma prior** to the release of the records:
  -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 cost of media, plus postage
  -Actual cost may be charged for unusual or uncommon record requests.
  (There is $10 fee for certification or similar documentation.)

☐ I will pick up copies of my records when called
☐ Fax my records to: (____) _____
☐ Mail copies of my records to the recipient above
☐ Other format (if available): _____

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

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