



Request for Health Information/Treatment Records
(For Use When Patient Wants Own/Child's Records for Self or Attorney±)

Patient Last Name: First: Middle:
Other Names Used: Birthdate:
Address: City: State: Zip:
Home Phone: Alt. Phone: Cell Phone:
If currently enrolled OU student, enrollment dates: to

I request [] access to, OR [] a copy of my protected health information checked below (or, if I am an OU student, my treatment /education record checked below)

From (date) to (date)

Maintained or created by this Provider or Clinic:

The records I request access to or a copy of are:

- [] 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 communicable or noncommunicable disease or mental health. Release of mental health records or psychotherapy notes may require consent of the treating provider or a court order.

- I agree that costs for records will not exceed the following amounts, payable to the University of Oklahoma prior to the release of the records:
- Paper Format - 50 cents per page, plus postage and mailer costs
- Digital Format - 30 cents per page, plus the cost of the digital media (disk, flash drive, etc.), plus postage and mailer costs
- X-ray/Film - \$5 per x-ray/film, plus cost of media, plus postage and mailer costs

- There is \$10 fee for certification, affidavit, or similar documentation.

[] I will pick up copies of my records when called
[] Fax my records to: ()
[] Other (if available):
[] Mail copies of my records to the address above
[] Mail copies of my records to the address below:
Firm/Attorney Name:
Firm/Attorney Address:

- I understand the information authorized for release may include substance use disorder records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). A general authorization for the release of medical or other information is not sufficient for this purpose. As a result, by signing below, I specifically authorize any such records included in my health information to be released. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. 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.

Signature of Patient, Parent, or Authorized Legal Representative**

Relationship to Patient

Date

**May be requested to show proof of representative status

± Includes personal representative or designates

University of Oklahoma Health Sciences Center, University Privacy Official, P. O. Box 26901, Oklahoma City, OK 73129