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| ou-logo | **The University of Oklahoma** |
| **Request for Health Information/Treatment Records****(For Use When Patient Wants Own/Child’s Records)** |
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| 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 [ ]  access to, OR [ ]  a copy of my protected health information (or, if I am an OU student, my treatment/education record) 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) | OR only these portions of my record: |
|  | [ ]  X-ray Reports/Films |
|  | [ ]  Immunization Records |
| [ ]  Entire Health Record plus Billing Records/Notes**\*** (Excludes Psychotherapy Notes\*) | [ ]  Discharge Summaries |
|  | [ ]  Medications |
|  | [ ]  Pathology/Lab Reports |
| [ ]  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.) | [ ]  Billing Records |
|  | [ ]  Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| * I agree that costs for records are as follows and are **payable to the University o**f **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 | [ ]  Mail copies of my records to the address above |
| [ ]  Fax my records to: (     ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | [ ]  Other format (if available):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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|  |  |  |  |  |
| **Signature of Patient, Parent, or Authorized Legal Representative\*\*** |  | **Relationship to Patient** |  | **Date** |

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

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