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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)** | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 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