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| ou-logo | | | | **The University of Oklahoma**  Enter Entity Here | | | | | | Insert College /Department Name  Insert College/Department Street Address  Insert College/Department City State and ZIP | | | | | | | |
|  | | | |  | | | | | |  | | | | | | | |
| **Consent for Electronic Communication of Medical Records** | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | |
| Last Name: | |  | | | | | First: |  | | | | Middle: | | |  | | |
| Other Names Used: | | | | |  | | Birthdate: | |  | | | | | | | | |
| Address: |  | | | | | | City: |  | | | State: | |  | | | Zip: |  |
| Home Phone: | | | ( ) | | | Alt. Phone: | | ( ) | | | Cell Phone: | | | ( ) | | | |
|  | | | | | | | | | | | | | | | | | |

I have submitted a Request for Health Information/Records and I authorize OU to send my records to me via email at the email address below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

- or -

I have submitted an authorization to Release Health Information/Records and I authorize OU to send my records to a third party via email at the email address below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**I understand the security of email and text messages cannot be guaranteed and that unauthorized individuals may be able to access the messages.**

I understand the information sent via electronic communication may include information that may indicate the presence of a communicable disease or non-communicable disease, mental health records, or substance use disorder records

It is my responsibility to notify OU if the email address information changes after submitting this form.

I understand that this service of electronic communication is offered solely at the discretion of the OU entity named above and may be withdrawn at any time.

**I understand and agree to the statements above and wish to have my records emailed to the recipient listed above.**

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

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