OKLAHOMA STATE UNIVERSITY
CENTER FOR HEALTH SCIENCES
CLINIC ADDRESS:
CLINIC ADDRESS:
PHONE: FAX:
AUTHORIZATION FORM

PHYSICIANS

Patient Information (Please Print)

Patient Name: Last First Middle

Address: Street Address City State Zip Code

Date of Birth Social Security Number Treatment Date(s)

I hereby authorize Oklahoma State University Center for Health Sciences and its duly authorized agents and employees to

□ RELEASE or □ OBTAIN or □ REVOKE

the protected health information indicated below to/from:

Name: _____ **Phone Number:** _____

Address: _____
Street Address City State Zip Code

Requested Information:

I authorize the disclosure of the following types of records created from _____ **to** _____**.**

- □ **Patient History**
- □ **Information created or received from other Providers**
- **Specify:** _____
- □ **Hospital & Consulting Physician summaries**
- □ **Billing Records**
- □ **Entire Designated Record Set**
- □ **Shot Records only**
- □ **Lab Reports**
- □ **X-Rays**
- □ **Radiology Reports**
- □ **Pathology Reports**
- □ **Other:** _____(For all , write "All")

(Please mark the above options that apply if revoking authorization)

The requested information is/was maintained or created by the following sites/providers:

Name of Physician or Provider	**Department**	**Clinic Address/Contact Name and Number**

***Note**: Unless you are a provider, you will be charged $1.00 for the first page and $.50 per page thereafter for paper records, $5.00 per film copied for radiology films, and postage. There is no fee for Revocation of authorization/consent.

Purpose of the Requested Use or Disclosure: □ Continued Care □ At the request of the patient ***Please skip this section if Revoking Authorization***

□ Other (Indicate specific reason)_____

Expiration Date:

This authorization will expire on ☐ _____ or ☐When the following event occurs: _____
(Not to exceed 6 months from the date of this request)

Your Rights: You may refuse to sign this authorization. Your refusal will not affect your ability to obtain treatment or payment. If this is a Revocation, it must be signed and dated or it is not valid.

1. If the persons or entities authorized to receive this information are not health care providers or health plans covered by federal health privacy laws, they may re-disclose the information and those laws would no longer protect the disclosed health information.
2. Once you sign this authorization, we can rely on it until you revoke it or, if you have not revoked it, until it expires. You can revoke an existing authorization by mailing this form filled out with "Revoke" marked, signed and dated or in person at: **HIPAA Compliance Officer, 717 South Houston, Suite 506 , Tulsa, Oklahoma 74127**
3. **The information authorized for release may include records which indicate the presence of a communicable and/or non-communicable disease. This may include records involving communicable disease, psychological or psychiatric conditions, and/or substance abuse.**
4. I understand that the records requested may be protected under 42 C.F.R. Part 2, governing Alcohol and Drug Abuse patient records, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. Parts 160 and 164, state laws and regulations regarding the confidentiality of medical records, and cannot be released without my consent unless otherwise provided for by applicable law. I understand also that state and federal laws and regulations prohibit any further disclosure of such records without my specific written consent, or when otherwise permitted by law.
5. ☐ If checked, we will receive compensation for our use/disclosure of the information that is the subject of this authorization.

Signature: _____ Date: _____
Patient or Legal Representative

Capacity of Legal Representative* (if applicable): _____

*To provide verification of representative status