Rev. July 2018

OKLAHOMA STATE UNIVERSITY
CENTER FOR HEALTH SCIENCES
DEPARTMENT NAME
ADDRESS
PHONE: FAX:

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient Name: _____ **Date of Birth:** _____
Last First Middle

Address: _____
Street Address City State Zip Code

Phone: _____ **Social Security Number:** _____

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

□ RELEASE or □ OBTAIN

the protected health information indicated below to/from:

Name: _____ **Phone:** _____ **Fax:** _____

Address: _____
Street Address **City** **State** **Zip Code**

Information to be Released/Disclosed: Records between the dates of _____ and _____

□ Patient History □ Lab Reports □ Mammogram Films & Reports □ Radiology Reports
□ Immunization Records □ Pathology Reports □ Ultrasound Films & Reports □ X-Rays Films & Reports
□ Billing Records □ Mental Health Records □ Substance Abuse Records □ Entire Designated Record Set
□ Psychotherapy Notes (If checking this box, no others may be checked) □ Other: _____

Purpose of the Requested Use or Disclosure: □ Insurance □ Continued Care □ Legal □ At the request of the patient or representative
□ Other (Indicate specific reason) _____

I understand:

- I can cancel this authorization at any time by submitting a written cancellation request to OSU-CHS Compliance Office, 717 S. Houston Ave., Suite 510, Tulsa, OK 74127. The cancellation will not apply to information that has already been used or disclosed based on this authorization.
- I have the right to receive a copy of this authorization.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, signing this authorization will not affect my eligibility for benefits, treatment, enrollment or payment of claims.
- My medical information may indicate that I have a communicable and/or non-communicable disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, HIV or AIDS and/or may indicate that I am being or have been treated for psychological or psychiatric conditions or substance abuse.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by privacy regulations.
- Unless requested for continued treatment, I may be charged reasonable costs and postage.

This authorization automatically expires six months from the date of signature below or upon occurrence of the following event: _____, whichever occurs first.

I voluntarily give my consent to the use and disclosure of individually identifiable health information and release Oklahoma State University and its duly authorized agents and employees from any liability in connection with the use or disclosure of the information contained herein.

Signature of Patient or Legal Representative _____ Date: _____

Printed Name and Authority of Legal Representative (if applicable): _____

TRANSLATOR USE ONLY: This is to certify that the above Authorization has been read to the patient (or representative) in his/her native language and all representations which appear in the Authorization were understood and authorized by the patient (or representative)

Translator: _____ Date: _____