

OKLAHOMA STATE UNIVERSITY

CENTER FOR HEALTH SCIENCES

**HEALTHCARE CENTER • HOUSTON PARKE • HOUSTON CENTER • OSUMC PHYSICIAN OFFICE BUILDING • EASTGATE METROPLEX
ENID • OSU TULSA • MUSKOGEE**

MEDICAL RECORDS

PHONE INQUIRY

REQUEST FOR PROTECTED HEALTH INFORMATION

Date: _____

PCN Account Number: _____

SUBJECTS TO COVER WITH PATIENT:

1. What is the patient's full name? _____

2. Who is the person calling, if different from the patient? _____

3. What is their relationship to the patient? _____

4. Return Phone Number: _____ Fax Number: _____

5. What is the patient's DOB? _____

6. What is the patient's SSN? _____

7. Who is/are the patient's Doctor(s)?

8. Has the patient signed a Release of Information?

YES

NO – Ask if the patient/person calling has access to a fax machine or do they want a release mailed?

Fax to: _____

Mail to: _____

9. VERIFY INFORMATION IS CORRECT BY REPEATING PHONE/FAX NUMBERS AND ADDRESS!

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.

COMMENTS/NOTES:

Person Documenting Phone Inquiry: _____