OKLAHOMA STATE UNIVERSITY
CENTER FOR HEALTH SCIENCES
HEALTHCARE CENTER · HOUSTON PARKE · HOUSTON CENTER · OSUMC PHYSICIAN OFFICE BUILDING · EASTGATE METROPLEX ENID · OSU TULSA · MUSKOGEE

REQUEST FOR ACCESS TO PROTECTED HEALTH INFORMATION

Notice to Patients: Your request for access to your Protected Health Information is ONLY applicable to the information maintained by OSU Center for Health Sciences. If you want access to information maintained by any other Provider or Facility, you must submit a separate request directly to that Provider or Facility.

PATIENT INFORMATION (PLEASE PRINT)

Patient Name: Last First Middle

Address: Street Address City State Zip Code

Home Phone Number Work Phone Number Other Names Used

Date of Birth Social Security Number Treatment Date(s)

I hereby request access to Inspect or Copy the Protected Health Information in my designated record set for the time frame beginning: _____ and ending: _____. The requested information is/was maintained or created by the following sites/providers at Oklahoma State University Center for Health Sciences:

Name of Physician or Provider	Department	Clinic Location

This request may be denied, in whole or in part, as outlined in the OSU Center for Health Sciences Notice of Privacy Practices. If the request is denied, a letter explaining the denial will be sent to you explaining the decision.

* **Note: Unless you are a provider, you will ne 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.**

I am requesting access to Inspect or Copy the following information maintained or created by the sites/providers listed above:

- □ **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: _____**

RELEASE TO: ☐ **I will pick up the copies of my record** ☐ **Mail copies of my record to:**
_____ Self _____ Legal Representative

Name: _____

Address: _____

Phone: _____ Fax: _____

The information authorized for release may include records which indicate the presence of a communicable or venereal disease including, but not limited to, hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS) and/or mental health information.

The information authorized for release may also include records related to mental health and/or substance abuse treatment.

I understand this authorization is only valid for ninety (90) days from the date of the signature below.

_____ _____ _____
Signature of Patient/Parent/Legal Guardian Relationship to Patient Date

INTERNAL USE ONLY

ACCESS ☐ Granted ☐ Denied Copy/Letter Sent On: _____

File in Patient Chart