



## FOR USE IN THE OSU CLINIC SYSTEM

### 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 \_\_\_\_\_

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Patient History              | <input type="checkbox"/> Lab Reports       | <input type="checkbox"/> Mammogram Films & Reports   |
| <input type="checkbox"/> Immunization Records         | <input type="checkbox"/> Pathology Reports | <input type="checkbox"/> Ultrasound Films & Reports  |
| <input type="checkbox"/> Substance Abuse Records      | <input type="checkbox"/> Billing Records   | <input type="checkbox"/> X-Rays Films & Reports  |
| <input type="checkbox"/> Mental Health Records        | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> Psychotherapy Notes (If checking this box, no other boxes may be checked) |
| <input type="checkbox"/> Entire Designated Record Set | <input type="checkbox"/> 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 have 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 federal privacy regulations.
- Unless requested for continued treatment, I will be charged \$.50 per page for records in print format, \$5.00 per film copied, 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:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Patient or Legal Representative

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: \_\_\_\_\_