The University of Oklahoma
OU Health Physicians

Medical Records Department
4444 E 41st St SCC 1912, Tulsa OK 74135
PH: 918-619-4491 FAX: 918-619-4493

Request for Health Information/Treatment Records
(For Use When Patient Wants Own/Child's Records for Self or Attorney±)

Patient Last Name: _____ First: _____ Middle: _____

Other Names Used: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: ( ) Alt. Phone: (____) _____ Cell Phone: (____) _____

If currently enrolled OU student, enrollment dates: _____ to _____

I request ☐ access to, OR ☐ a copy of my protected health information checked below (or, if I am an OU student, my treatment /education record checked below)

From (date) _____to (date) _____

Maintained or created by this Provider or Clinic: _____

The records I request access to or a copy of are:

☐ Entire Health Record*
Excludes Billing Records/Notes and Psychotherapy Notes

☐ Entire Health Record plus Billing Records/Notes*
Excludes Psychotherapy Notes

☐ Psychotherapy Notes* (if checking this box, no other boxes may be checked. A separate copy of this form must be completed to obtain any other types of records.)

OR only these portions of my record:

☐ X-ray Reports/Films
☐ Immunization Records
☐ Discharge Summaries
☐ Medications
☐ Pathology/Lab Reports
☐ Billing Records
☐ Other: _____

_____

*The information authorized for release may include information related to communicable or noncommunicable disease or mental health. Release of mental health records or psychotherapy notes may require consent of the treating provider or a court order.

- I agree that costs for records will not exceed the following amounts, **payable to the University of Oklahoma prior** to the release of the records:
  - Paper Format – 50 cents per page, plus postage and mailer costs
  - Digital Format – 30 cents per page, plus the cost of the digital media (disk, flash drive, etc.), plus postage and mailer costs
  - X-ray/Film - $5 per x-ray/film, plus cost of media, plus postage and mailer costs
- There is $10 fee for certification, affidavit, or similar documentation.

☐ I will pick up copies of my records when called
☐ Fax my records to: (_____) _____
☐ Other (if available):_____
_____

☐ Mail copies of my records to the address above
☐ Mail copies of my records to the address below:
Firm/Attorney Name: _____
Firm/Attorney Address: _____

☐ I understand the security of email cannot be guaranteed and that unauthorized individuals may be able to access the message. I understand the information sent via electronic communication may include information that may indicate the presence of a communicable disease or non-communicable disease, mental health records, or substance use disorder records. It is my responsibility to notify OU if my email address information changes after submitting this form. **I understand and agree to the statements above and wish to have my records sent to me via email at the address below.**

_____@_____.

- I understand the information authorized for release may include substance use disorder records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). A general authorization for the release of medical or other information is not sufficient for this purpose. As a result, by signing below, I specifically authorize any such records included in my health information to be released. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. The Federal rules prohibit anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by 42 CFR Part 2.

Signature of Patient, Parent, or Authorized Legal Representative**	**Relationship to Patient**	**Date**

****May be requested to show proof of representative status**

± Includes personal representative or designates