The University of Oklahoma
Goddard Health Center

Goddard Health Center
620 Elm Avenue
Norman, OK 73019

Authorization to Release Health Information/Treatment Records

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 that the health information (or, if I am a student, my treatment/education record) checked below from, (date)_____ to (date) _____ maintained or created by the Provider named below be released to the Recipient named below.
- Initial here if information from your records may also be disclosed **verbally** to the recipient below:_____

Purpose of Request: ☐ referral ☐ legal ☐ transfer ☐ other:_____

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

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

☐ 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
☐ Billing Records ☐ Pathology/Lab Reports
☐ Other: _____
_____

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

Release Records From Provider/Clinic:			***Provide Records To Recipient:***		
Name: Goddard Health Center			Name:		
Address: 620 Elm Avenue			Address:		
City: Norman	State: OK	Zip:73019	City:	State:	Zip:
Fax: 405-325-7542	Phone: 405-325-2555		Fax:	Phone:	

I understand:

- I may revoke this Authorization at any time by providing my written revocation to the address at the bottom of this form. My revocation will not apply to information already retained, used, or disclosed under this Authorization. Unless sooner revoked, the automatic expiration date of this Authorization will be _____ months from the date of signature (12 months, if none entered).
- Unless the purpose of this Authorization is to determine payment of a claim or benefits, OU may not condition the provision of treatment or payment for my care on my signing this Authorization.
- Information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy law. Student treatment/education records may retain continuing privacy protections in accordance with 34 CFR Part 99 (FERPA).
- 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.
- 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.

☐ Recipient will pick up copies of my records when called ☐ Mail copies of my records to the Recipient address above
☐ Fax my records to the Recipient : (____) _____ ☐ Other (if available): _____

☐ 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 the email address information changes after submitting this form. **I understand and agree to the statements above and wish to have my records sent to the Recipient via email at:** _____@_____.

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

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

University of Oklahoma Health Sciences Center, University Privacy Official, P. O. Box 26901, Oklahoma City, OK 73129