The University of Oklahoma
OU Health Services
Goddard Health Center
620 Elm Avenue
Norman, OK 73019-3146

**ACKNOWLEDGEMENT OF RECEIPT OF
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have been provided the University of Oklahoma's ("OU") Notice of Privacy Practices ("Notice").

- The Notice tells me how OU will use my health information for the purposes of my treatment, payment for my treatment and OU's health care operations.
- The Notice explains in more detail how OU may use and share my health information for purposes other than treatment, payment and health care operations.
- OU will also use and share my health information as required/permitted by law.
- If I am an OU student receiving student health services, I consent to OU using and disclosing my treatment and education records it maintains for the purposes detailed in OU's Notice of Privacy Practices.

Patient's COMPLETE Legal Name: ____
Please Print Legibly

Patient's Date of Birth: ________________
Month Day Year

SIGNATURE
Of Patient: ____ Date: _____________________

SIGNATURE of Legally
Authorized Guardian
Or Representative if
Patient is a Minor*: _________________________________ Date: _____________________
* May be requested to show proof of representative status.

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**CONSENT FOR USE OF PROTECTED HEALTH INFORMATION FOR
IN-OFFICE TREATMENT, PAYMENT AND OPERATIONS**

I consent to the use of my Protected Health Information for treatment, payment for treatment, and OU's health care operations purposes for myself or for the patient for whom I am the parent or legally authorized representative. I understand that the University of Oklahoma ("OU") will share patient protected health information according to the federal and state law for treatment, payment, and operations, as well as in accordance with its Notice of Privacy Practices.

I understand that the patient is responsible for all charges incurred, regardless of the patient's insurance status. I agree that the patient must pay for services as the patient incurs the charges. I authorize OU to provide necessary information to the patient's insurance carrier or other payer for payment purposes, and I authorize my insurance company/payer to pay OU for services filed on my behalf. This assignment remains effective until I revoke it in writing.

If I am an OU student seeking student health services or treatment, I consent to the release of my treatment/education records for payment for services rendered to my insurance carrier or payer and authorize the carrier or payer to pay OU for services rendered.

Patient's COMPLETE Legal Name: ____
Please Print Legibly

Patient's Date of Birth__________________
Month Day Year

SIGNATURE
Of Patient: ____ Date: __________________

SIGNATURE of Legally
Authorized Guardian
or Representative if
Patient is a Minor*: __________________________________ Date: __________________
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This completed form is required at each visit if you are not covered by insurance or covered by Soonercare, Medicaid or the Oklahoma Health Care Authority.

If you are not covered by Insurance, please circle:

NO COVERAGE Initials___________

Do you have Soonercare, Medicaid or Oklahoma Health Care Authority Coverage?

YES__________ NO___________ Initials_________

Goddard Health Center is not a Soonercare/Medicaid/Oklahoma Health Care Authority provider and cannot be your Soonercare/Medicaid/Oklahoma Health Care Authority home. Soonercare/Medicaid/Oklahoma Health Care Authority will not cover the cost for your visit, any services received or any prescriptions written by our Goddard provider.

You will be responsible for all charges for your visit and services, including prescriptions from Goddard providers and will receive a Bursar statement for all charges not paid at the time of service.

If you have questions about what you will be required to pay, you may ask Patient Services or the Pharmacy for cost estimates prior to receiving services or filling a prescription.

I understand this information and would like to receive services at Goddard Health Center and am willing to pay for all charges incurred.

Signature ____

Date ________________________

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If you are covered by insurance, please complete the following:

Has any of the information changed since your last visit? Yes ___ or No ___

Primary Insured/Policy Holder Information *for your medical insurance*
(this is the person who "owns" the insurance if not you):

Last Name ____

First Name ____

Middle Name or Initial ______________________________________

Date of Birth ____

Mailing Address ____

City ____________________ State ____________ Zip Code ______________

Insurance Company ____

Insurance ID # ____

Insurance Group # ____

Patient's Relationship to Primary Insured ____________________________

Your medical insurance cards (or complete information) are required to file your insurance in both the clinic and the pharmacy. Please be aware you will receive a Bursar statement for the remainder of any charges after insurance has processed your claim. If you have questions about what your insurance will pay or whether your insurance is in-network, please contact your insurance carrier. Your OU ID will be required at the time of service in the clinic. Your OU ID and your Driver's License (for some prescriptions) will be required at the time of service in the pharmacy.

I understand I am responsible for all charges not paid by my insurance and want to receive services at Goddard Health Center on the OU Norman Campus.

Patient Printed Name ____________________________________

Signature ____

OU ID ____________________________ Date _______________

Revised 10/2022

The University of Oklahoma
OU Health Services

Goddard Health Center
620 Elm Avenue
Norman, OK 73019-3146

Request and Consent for Electronic Communication - Health Connection Secure Patient Portal, Texting and Emailing

Last Name: ______________________________ First: ______________________ Middle: _________________________
(Please use full legal name)

Other Names Used: _______________________ Birthdate: ____

Email Address (OU Email preferred): ____

HealthConnection Secure Patient Portal information and authorization:

OU Health Services offers its patients access to their lab results, appointment times, and secure messaging to and from their providers, and certain health information via a secure patient portal.

I agree to not share my password for the Secure Patient Portal (HealthConnection) with others as unwanted access to my information may occur. I understand that OU Health Services will not ask me for my Email Address password or my Secure Patient Portal (HealthConnection) password. These passwords are my sole responsibility for upkeep. If I forget my password, I will be required to request a new password or register again.

I understand the information on the Secure Patient Portal (HealthConnection) may include information that may indicate the presence of a communicable disease or non-communicable disease.

☐ **I understand and agree to the statements above and wish to have electronic communication sent to me by OU Health Services through the Secure Patient Portal.**

☐ **I decline electronic communication through the Secure Patient Portal. I understand I will not have access to secure online lab results, appointments, referrals, or messaging to or from my provider.**

Texting information and Authorization:

I understand that I should not use electronic communication such as text messages to contact my provider in the case of emergency. I understand that it is my responsibility to notify OU at the above telephone or address if my contact information changes.

If checked below, I consent to having appointment reminders and notices about health events (such as flu shot clinics) sent to me at the cell number listed below. Appointment reminders will include my name, the date and time of my appointment. I understand that text messages are not generally secure and may be intercepted by unauthorized individuals. While not anticipated, it is possible that text messages may also include information about my treatment, including information about a communicable or non-communicable disease.

I authorize OU to communicate with me via:

☐ text: (_____)____________________

I understand that refusal to sign this form will not affect my ability to obtain treatment from OU Health Services.

I understand that I may revoke my consent at any time by providing OU Health Services with a verification of my identity and completing the Request for Alternative Communication form. Revocation will not apply to communications that have been sent prior to the revocation date.

I understand that this service of electronic communication and Secure Patient Portal is offered solely at the discretion of OU Health Services and may be withdrawn at any time.

I understand this is not a request for release of my medical records.

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

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

University of Oklahoma
OU Health Services
620 Elm Avenue
Norman, OK 73019-3146
405-325-4611

PATIENT DATABASE

Please Print Legibly & Complete Entire Form

Today's Date: ______________________

Patient's Full Name: (Last, First, Middle Initial)	Please call me by this name:
Local Address: (Street, City, State, Zip)	
Permanent Address: (Street, City, State, Zip)	
Cell Phone:	Home Phone / Work/Other Phone:
Emergency Contact Name:	
Relationship:	Phone:

Sooner ID #:

OU Email Address:

Date of Birth:

Race:
- ☐ American Indian/Alaska Native
- ☐ Asian
- ☐ Black/African American
- ☐ Pacific Islander/Native Hawaiian
- ☐ White
- ☐ Other________________

Hispanic/Latino Ethnicity: ☐ Yes ☐ No

Sex Assigned At Birth: ☐ Male ☐ Female

Gender Identity________________

Pronouns ________________

Social History:

Are you a: ☐ Student ☐ Faculty/Staff ☐ Dependent

Relationship Status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Do you smoke or vape? (circle smoke/vape) ☐ No ☐ Yes If you have smoked in the past, how many years and when did you quit? ______________

Do you use other tobacco products? ☐ No ☐ Yes If yes, what type and how often? ______________

Do you drink alcohol? ☐ No ☐ Yes If yes, what type and how often? ______________

Do you use marijuana or THC? ☐ No ☐ Yes If yes, what type and how often? ______________

Do you use recreational drugs? ☐ No ☐ Yes If yes, what type and how often? ______________

Are you or have you ever been sexually active? ☐ No ☐ Yes If yes: ☐ Men ☐ Women ☐ Both

Allergies: ______________________________
medications, outdoor allergens, food, etc.

Health History:

Anemia	Y N	Depression/Anxiety/Panic	Y N	Head Injury	Y N	Muscle/Nerve Disorder	Y N
Arthritis	Y N	Diabetes	Y N	Headache (Recurrent)	Y N	Rheumatic Fever	Y N
Asthma	Y N	Disability/Handicap	Y N	Heart Disease/Problems	Y N	Sexually Transmitted	
Back Problems		Drug Abuse__________	Y N	Hepatitis/Jaundice	Y N	Disease ____________	Y N
(Severe or Recurrent)	Y N	Ear Trouble/Hearing Loss	Y N	High Blood Pressure	Y N	Sickle Cell Trait/Anemia	Y N
Bleeding Disorders	Y N	Eating Disorder	Y N	Intestinal/Stomach Trouble	Y N	Sleep Problems	Y N
Cancer	Y N	Eye Disease/Problems	Y N	Joint Disease/Injury	Y N	Stroke	Y N
Convulsions/Seizures	Y N	Gallbladder Trouble	Y N	Kidney/Bladder Problems	Y N	Thyroid Disease	Y N
Cough (Chronic)	Y N	Hay Fever (Allergies)	Y N	Mononucleosis, Infectious	Y N	Tuberculosis	Y N

Other: ______________________________
Brief explanation of any marked yes

Surgeries, hospitalizations, fractures ______________________________

______________________________ Height:__________ Weight:__________

Family Health History: Have your family members (birth parents, grandparents, brothers or sisters) ever had any of the following?

Alcoholism Y N Drug problem Y N Mental illness Y N Diabetes Y N High Blood Pressure Y N Genetic Disease Y N

Asthma Y N High Cholesterol Y N Cancer Y N Heart disease or stroke under age 50 Y N

Other significant family illness (specify) ______________________________

I verify that the information provided on this form is correct. ______________________________
Patient's Signature

Chart Number: ____________________ *Reviewed By:* ____________________

Welcome to

OU Health Services online

HealthConnection

- Send messages anytime
- Secure communication
- Refill your prescriptions
- Get lab results without making a call

Not yet registered?

Register now on the login page:
healthconnection.ou.edu

1. Register as a new user
   a. Create a User Name
   b. OU ID number*

1. This is NOT your 4 x 4 number. Dependents of faculty/staff and students will need to come to our office to obtain the appropriate Sooner ID number.

a.
b.

Register
User Name
User Name
University ID
University ID
Submit

2. An email will be sent to the email address we have on file to confirm your registration. Please call our office (405.325.4611, press '4') or email *healthconnection@ou.edu* if you do not receive the email within one hour.

Online Messages

You may request lab or other test results. Please allow two weeks for non-urgent labs.

You may request prescription refills. Provide as much information as you know about your prescription including the prescription number, the date last filled, the drug name, your preferred pharmacy and the prescribing physician/physician assistant. Please allow 2-3 working days for refills.

You may request renewals of referrals to specialists. *If the referral is for a new condition, you must make an appointment with your provider at OUHS.* Provide your specialist's name, phone number and the last date of visit. Allow two weeks for an insurance authorization to be processed.

Important Things to Remember:

- HealthConnection will notify you through email when you have a message waiting. You must then login to the secure site to receive your message.
- HealthConnection will not send private health information to your email account.
- You may access the accounts of your dependents who are under age 18. You may not access the accounts of your spouse or dependents who are of legal age. They must set up their own account.
- Only use HealthConnection for non-urgent requests.

The University of Oklahoma is an equal opportunity institution. Accommodations on the basis of disability are available by contacting Health Services at (405) 325-4611.

Quick Guide to Health Insurance

Health Insurance can be confusing and OU Health Services at Goddard Health Center wants to provide you with resources to navigate your insurance plan.

OU Student Health Plan

OU Health Services is in-network with the OU Student Health Plan. Most services are covered 100% when you receive care at Goddard Health Center. Please refer to your plan booklet regarding specific coverage details.

OU Cigna Health Plan

OU Health Service is in-network with OU CIgna health plans. Please refer to your plan booklet regarding specific coverage details.

For all other Insurance Plans

OUHS is contracted with many major insurance companies and will file most insurance with a U.S. address, even if we are not contracted or are out-of-network with the plan. However, this does not guarantee that the insurance company will cover all the costs of services. **Only your insurance** can tell you if specific services are covered and will be paid. Contact your insurance company and discuss your coverage if you have questions about your out-of-pocket costs. Please be sure to check with your insurance company to see if OUHS is “in” or “out” of network with your plan.
If OU Health Services is out-of-network, and not a partner with your insurance company, you may have to pay part or all of the bill yourself.

How to find out if OU Health Services is In-Network with your Plan

Contact your insurance company customer service line. This number is usually found on the back of your card. Please be aware that you may not find our providers in an online search of your insurance directory. We are normally “directory suppressed” because we only see patients affiliated with the University.

Be prepared to ask these questions:

- Does my insurance pay for health care services provided by OU Health Services?
- Is OU Health Services “In” or “Out” of network with my insurance?
- Will I need a primary care provider’s referral, in order for my insurance to pay for care at OUHS?

You will need to provide the following information:

- **Facility Name:** We are listed as *Board of Regents, The University of Oklahoma, OU Health Services.*
- **NPI number of our facility**: Our facility NPI # is 1548372626.
- **Provider name and NPI number:** You may use Wesley Andrews, MD as a sample provider. (NPI # 1275566358).
- **Address:** 620 Elm Avenue, Norman OK, 73019.

For more information about billing and insurance, please visit our website:
https://https://www.ou.edu/healthservices/appointments/billing

Patient *Rights & Responsibilities*

OU Health Services is dedicated to providing you with the best in healthcare services. Along with medical expertise, we want to provide you with a positive patient experience. We respect your rights as a patient and want you to understand your responsibility as a partner in your care. These rights may be exercised by all patients who may legally self-consent for care or other persons authorized to act on the patient's behalf, and they accept these patient responsibilities as well.

Rights | *OU Health Services affords you, our patient, the right to:*

- receive healthcare services regardless of age, race, gender, religion, disability, national origin, or sexual orientation.
- be provided appropriate dignity and privacy both at check-in and in the evaluation/treatment areas.
- be offered interpretation services.
- be ensured of the confidentiality of all records pertaining to your care and treatment.
- expect information concerning diagnosis, evaluation, treatment, prognosis and informed consent to be explained clearly.
- participate in decisions regarding your health care.
- voice grievances regarding treatment or care and be informed on methods for providing feedback, including complaints.
- request a second opinion or change to another qualified provider.
- request your advanced directive to be included in your medical record.
- know the identity and credentials of the health care professional providing services.
- receive information concerning services available.
- receive information pertaining to fees for service and payment policies.
- be made aware of provisions for after hours and emergency care.
- refuse treatment (except in cases required by law) and be informed of the consequences of your actions.
- express your concerns if these rights have not been met.

Responsibilities | *It is your responsibility as the patient to:*

- provide accurate and complete information relating to your health history and current health status.
- follow the treatment plan prescribed by your health care provider.
- accept personal responsibility for refusing treatment.
- provide a responsible adult to transport you home from the facility, if medically advised.
- accept personal financial responsibility for services received, arrange for payment for services rendered, and provide the information necessary to obtain insurance or other third-party payments.
- conduct yourself in a respectful manner giving consideration to other patients and health center personnel.
- keep appointments as scheduled or notify us in advance if you are unable to do so.
- ask adequate questions to ensure understanding of your treatment.

HEALTH SERVICES
The UNIVERSITY *of* OKLAHOMA

UNIVERSITY OF OKLAHOMA - NOTICE OF PRIVACY PRACTICES

EFFECTIVE DATE: April 14, 2003

LAST REVISED: July 1, 2024

This NOTICE describes your rights regarding your medical information and informs you of how it may be used and disclosed. It applies to the health information that is protected by the Health Insurance Portability and Accountability Act (HIPAA), used to make decisions about your care, and generated or maintained by the University of Oklahoma (OU). Please review it carefully.

By law, OU must protect the privacy of your health information, give you this Notice of OU's legal duties and privacy practices, and follow the current Notice. It will be followed by all employees, students, and volunteers of the health care components of OU, that are covered by HIPAA.

1. Permitted Uses and Disclosures of Your Health Information

The following describes some of the ways that OU may use or disclose your health information without your authorization:

Treatment: To provide you with medical treatment/services and for treatment activities of other health care providers. *Examples:* Your health information may be used by doctors and students involved in your care. OU may use an electronic prescribing gateway with pharmacies.

Payment: For payment activities, such as to determine plan coverage or to bill/collect your account. *Example:* Your health information may be released to an insurance company to get pre-approval for services or to a collection agency if your account is not paid.

Operations: For uses necessary to run OU's healthcare businesses. *Example:* OU may use your health information to conduct internal audits to verify proper billing procedures.

Health Information Exchange/Regional Health Information Organization: In a health information exchange (HIE), an organization in which providers exchange patient information to facilitate health care, health care operations, avoid duplication of services (such as tests) and reduce the likelihood of medical errors. By participating in an HIE, OU may share your health information with other providers who participate in the HIE or participants of other HIEs. If you do not want your medical information in the HIE, you must request a restriction using the process outlined in paragraph 6 below or by contacting the HIE.

Education: To faculty, staff, current and prospective students, volunteer and visiting faculty, and trainees and observers as part of its educational mission. Education is part of OU's healthcare operations and treatment programs. *Example:* Your provider may discuss your case with students as part of a learning experience.

Business Associates: To other entities that provide a service to OU or on OU's behalf that requires the release of your health information, such as a billing service, but only if OU has received satisfactory assurance that the other entity will protect your health information.

Organized Health Care Arrangements and Affiliated Covered Entities: OU healthcare components have entered into an Organized Health Care Arrangement with Affiliated Covered Entities, such as OU Health. Protected Health Information may be shared and available to the Affiliated Covered Entity Workforce Members, such as OU Health Workforce Members, as is necessary to carry out treatment, payment, and health care operations. Physicians and other Workforce Members may have access to Protected Health Information to assist in treatment, payment, and healthcare operations as necessary.

Individuals Involved in Your Care or Payment for Your Care: To a friend, family member, or legal guardian who is involved in your care or who helps pay for your care.

Research: To researchers for Research if the authorization requirement has been waived or revised by a committee charged with making sure the disclosure will not pose a great risk to your privacy or that steps are being taken to protect your health information, to researchers to prepare for research under certain conditions, and to researchers who have signed an agreement promising to protect the information.

Organ and Tissue Donation: To donation banks or organizations that handle organ or tissue procurement or transplantation, if you are an organ or tissue donor.

Fundraising: Through OU's organized health care arrangement (OHCA) with OU Health, you may be contacted by OU Health, OU, and/or the OU Foundation for fundraising purposes. OU may use or release to the OU Foundation or OU Health your name, DOB, address, department of service, outcome, physician, insurance status, and treatment dates for fundraising. If you do not want to be contacted for fundraising efforts, notify OU's Privacy Official at the phone number or address in Paragraph 6 below. OU will not sell your health information without your written permission.

Marketing: To send you information regarding treatment alternatives or other health-related products, benefits, or services. You may opt out of receiving these communications by notifying OU's Privacy Official at the phone number or address in paragraph 6 below.

Other: We may also use and disclose health information:

- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- For population-based activities relating to improving health or reducing healthcare costs;
- For conducting training programs or reviewing competence of health care professionals; and
- To a Medicaid eligibility database and the Children's Health Insurance Program eligibility database, as applicable.

When disclosing information related to appointment reminders or quality or research surveys, we may text you the information or a link for participation.

2. Required Uses and Disclosures of Health Information: The following describes some of the ways that OU may be allowed or required by law to use or disclose your health information without your authorization:

Required by Law/Law Enforcement: If required by federal, state, or local law, such as for workers' compensation, and if requested by law enforcement officials for certain purposes such as to locate a suspect or in response to a court order.

Public Health and Safety: To prevent a serious threat to the health and safety of you, others, or the public and for public health activities. *Example:* Oklahoma law requires OU to report birth defects and cases of communicable disease.

Food & Drug Administration (FDA) and Health Oversight Agencies: To the FDA and manufacturers to enable product recalls, repairs, or replacements; and

to health oversight agencies for activities authorized by law, such as audits or investigations.

Lawsuits/Disputes: If you are involved in a lawsuit/dispute and have not waived the physician-patient privilege, OU may disclose your health information under a court/administrative order or subpoena.

Coroners, Medical Examiners, and Funeral Directors: To coroners, medical examiners, or funeral directors to enable them to carry out their duties.

National Security/Intelligence Activities and Protective Services: To authorized national security agencies for the protection of certain persons or to conduct special investigations.

Military/Veterans: To military authorities if you are an armed forces or reserve member.

Inmates: If you are an inmate of a correctional facility or are in the custody of law enforcement, OU may release your health information to a correctional facility or law enforcement official so they may provide your health care or protect the health and safety of you or others.

If OU wants to use and/or disclose your health information for a purpose not in this Notice or not required or permitted by law, *OU must get authorization from you for that use and/or disclosure, and you may revoke it at any time by contacting the Privacy Official at the phone number or address in Paragraph 6.*

OU must obtain your authorization for most uses or disclosures of your psychotherapy notes and substance use disorder records. Some exceptions include use for Treatment by your provider or disclosures required by law.

3. Your Rights Regarding Your Health Information: You have the following rights in regard to the health information that is protected by HIPAA that OU maintains about you. You must submit a written request to exercise any of these rights. Request forms are available at any of the locations where OU provides medical services. You also can get the forms by contacting the University's Privacy Official at the number or address in Paragraph 6 or at https://apps.ouhsc.edu/hipaa/forms-patients.asp**.**

Right to Inspect/Copy: To review and get a copy of your health information. This right does not apply to psychotherapy notes and certain other information. OU may charge for its costs for the copies and supplies, plus postage, payable prior to the release of the requested records. OU may deny your request in certain circumstances. You may request a review of a denial based on medical reasons; OU will comply with this decision.

Right to Amend: If you believe health information OU created is inaccurate or incomplete, you may ask OU to amend it. You must provide a reason for your request. OU may deny your request if you ask to amend information that OU did not create (unless the creator is not available to make the amendment); that is not part of the health information OU maintains; that is not part of the information you are permitted by law to review and copy; or that is accurate and complete.

Right to Accounting of Disclosures: To ask for a list of disclosures OU has made of your health information. OU is not required to list all disclosures, such as those you authorized. *You must state a time period, which may not be longer than 6 years, or include dates before April 14, 2003*. If you request more than one accounting in a 12-month period, OU may charge you for the cost. OU will tell you the cost; you may withdraw or change your request before the copy is made.

Right to Request Restrictions: To request a restriction or limit on how OU uses or discloses your health information. Your request must be specific. You may restrict disclosure of your health information to a health plan only if the disclosure is for payment or health care operations and pertains to a Health Care item or Service for which you pay out-of-pocket in full at the time it is provided. OU is not required to agree to other requests. If OU agrees or is required to comply, OU will comply with the request unless the information is required to be disclosed by law or is needed in case of emergency. *Example*: You may want to pay cash in advance for services rather than have your insurance billed.

Right to Request Confidential Contacts: To request that OU contact you in a certain way, such as by mail. You must specify in writing how or where you wish to be contacted; OU will try to accommodate reasonable requests.

Right to a Copy of This Notice: To receive a paper or electronic copy of this Notice, which is posted and available at each location where medical services are provided and is on OU's website.

Right to Designate a Representative: If you have given someone a medical power of attorney or have a legal guardian, that person can exercise your rights under HIPAA and make choices about your health information. We may require proof of this person's status.

4. Changes to this Notice: OU reserves the right to change this Notice and to make the revised Notice effective for health information OU created or received about you prior to the revision, as well as to information it receives in the future. Revised Notices will be posted and available at each location where medical services are provided and on OU's website.

5. Right to be Notified. You have the right to be notified of breaches that may have compromised the privacy or security of your health information.

6. Information/Complaints. If you believe your privacy rights have been violated, you may file a complaint with OU's Privacy Official, Sandra Nettleton, at (405) 271-2511; OU Compliance@ouhsc.edu; or PO Box 26901, OKC, OK 73126-0901; or with the Secretary of the Department of Health and Human Services, Office for Civil Rights – DHHS, 1301 Young Street, Suite 1169, Dallas, TX 75202, (800) 368-1019; (800) 537-7697 TDD; Email: ocrmail@hhs.gov.

Complaints must be submitted within 180 days of when you knew or should have known of the circumstance leading to the complaint. **You will not be retaliated against for filing a complaint.**

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

OU Office of Compliance
P O Box 26901
Oklahoma City, OK 73126-0901
Phone (405) 271-2511
Fax (405) 271-1076

Anonymous Reporting –
OU Report IT!
Phone: (844) 428-6531

Online:
https://ouregents.ethicspoint.com

Si necesita recibir este aviso en español, favor de ponerse en contacto con la Oficina de Cumplimiento anotada arriba.