MEDICINE | University Health Services

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Stillwater, OK 74078
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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION (PHI)

Patient Name:_____ **Date of Birth:** _____
Last First Middle

Address:_____
City State Zip Code

Phone: _____ **Banner ID:** _____

I hereby authorize Oklahoma State University (OSU) Health Services (UHS) and its duly authorized agents and employees to

☐ RELEASE or ☐ OBTAIN

the protected health information indicated below to/from:

Facility Name:_____**Phone:**_____**Fax:** _____

Address: _____
City **State** **Zip Code**

Information to be Released/Disclosed: Records between the dates of _____ and _____.

☐ Patient History ☐ Lab Reports ☐ Mammogram Films & Reports ☐ Radiology Reports

☐ Immunization Records ☐ Pathology Reports ☐ Ultrasound Films & Reports ☐ X-Rays Films & Reports

☐ Billing Records ☐ Mental Health Records ☐ Substance Abuse Records

☐ Entire Designated Records Set ☐ Psychotherapy Notes (**if checking this box, no others may be checked**)

Other: _____

Purpose of the Requested Use or Disclosure: ☐ Insurance ☐ Continued Care ☐ Legal ☐ Patient or Representative Request

☐ Other (Indicate specific reason) _____

I understand:

- I can cancel this authorization at any time by submitting a written cancellation request to OSU-UHS Business Office, 1202 W Farm Rd, Stillwater, OK 74075. 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 am being 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 privacy regulations.
- Unless requested for continued treatment, I may be charged reasonable costs 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 UHS my consent to the use and disclosure of individually identifiable health information and release OSU and its duly authorized agents and employees from any liability in connection with the use or disclosure of the information contained within.

Signature of Patient or Legal Representative_____Date: _____

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 that appear in the Authorization are understood and authorized by the patient (or representative).Translator:
_____Date:_____

UHS Clinic Use Only
Released By: _____ Date: _____ Mail/Fax: _____ Pick up: _____