OSU University Health Services

Stillwater, OK 74078-2036 405-744-7665 Fax: 405-744-6556 uhsfax@okstate.edu

This form authorizes UHS to use or disclose the personal health information listed below for the purposes stated below.

Printed Name:______________________CWID:__________________DOB:____________Phone:________________

Facility/Person authorized to **SEND** information

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PH____________________Fax_________________

Facility/Person authorized to **RECEIVE** information

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PH______________________Fax________________

*I understand this information may be transmitted by fax if necessary for **urgent** medical care.*

THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE, NON-COMMUNICABLE, OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA AND HUMAN IMMUNODEFICIENCY VIRUS ALSO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

I also understand that I may revoke (in writing) this consent at any time except to the extent that action has been taken in reliance on and I also understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. In any event this consent expires automatically as described below. Specification of the date, event or condition upon which this consent expires _______________ not to exceed 12 months, *if left blank this consent expires six months from date of signature*.

Personal Health Information to be used or disclosed:

_____ Progress Reports; _____ Lab, EKG, and/or X-ray CD/reports; _____ Billing Information

_____ Other ____

_____ Entire record of care provided by this office's health care professionals exclusive of the four items below. If you wish any of these 4 items transferred, you must initial.

	Include		Include
AIDS or AIDS(HIV) antibody test results		Alcohol or substance abuse or treatment	
Records from other provider offices (This will include everything transferred to us.)		Psychiatric/mental health diagnosis or treatment	

I understand that once disclosed this information may be re-disclosed by the recipient who might not be subject to HIPAA regulations, which means the information may no longer be protected. More information regarding your privacy rights is found in the UHS Notice of Privacy Practices. I understand that UHS does not condition treatment upon my willingness to sign this authorization. If the person requesting this authorization for use of PHI is **NOT** the individual, please state the authority under which this request is being made:____

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Signature of Patient (or if under 18 years of age, Parent, Legal Guardian, Legal Representative) Date

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Clinic Use Only

Released By: ______________ Date: _______________ Mail/Fax _____ Pick up _____ Call when ready ___________