



Medical Record #: \_\_\_\_\_

Request Made:  In Person  
 Written

Type of Request:  Release  Obtain

**AUTHORIZATION TO RELEASE OR OBTAIN INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION**

Patient Name	Phone No.	Date of Birth	Last 4 digits Social Security No.
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By signing below, I hereby authorize Oklahoma Cancer Specialists and Research Institute and its duly authorized agents and employees to RELEASE or OBTAIN to/from the person or organization listed below, my individually identifiable health information for the use and disclosure described below. I do not authorize further release to any third party.

**PERSON OR ORGANIZATION INFORMATION IS TO BE RELEASED TO OR OBTAINED FROM AND PURPOSE OF RELEASE**

<i>Person/Organization to release or obtain from my information (include address)</i>			<i>Purpose of release/obtain:</i>	
Name of Person or Organization			<input type="checkbox"/> Filing insurance	
Street			<input type="checkbox"/> Continued treatment	
City			<input type="checkbox"/> Request of patient or their legal representative	
State			<input type="checkbox"/> Other (specify): _____	
Zip				

**INFORMATION TO BE USED OR DISCLOSED – Check all that apply**

<input type="checkbox"/> Surgical Reports	<input type="checkbox"/> History and Physical	<input type="checkbox"/> Progress Notes	<input type="checkbox"/> Entire Chart (ALL ITEMS LISTED)
<input type="checkbox"/> Radiology Images	<input type="checkbox"/> Operative Report	<input type="checkbox"/> Treatment Plan(s)	<input type="checkbox"/> View Electronic Records
<input type="checkbox"/> Laboratory Reports	<input type="checkbox"/> Genetic Testing Results	<input type="checkbox"/> Demographics (providers only)	<input type="checkbox"/>
<input type="checkbox"/> Radiology Reports	<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> HIPAA Authorization	<input type="checkbox"/>
<input type="checkbox"/> Pathology Reports	<input type="checkbox"/> Radiation Reports	<input type="checkbox"/> Biopsy Reports	<input type="checkbox"/> Other _____

**TREATMENT DATES REQUESTED – Check one**

All dates of service **OR**  Treatment dates between \_\_\_\_\_ and \_\_\_\_\_

**REQUEST TO RECEIVE INFORMATION ELECTRONICALLY**

*I will receive the information via a CD, unless otherwise specifically requested in paper.*

*Must have in paper format (I understand paper will cost me extra)*

**I UNDERSTAND:**

- This authorization will expire 12 months from date signed
- **The information authorized for use or disclosure may include information which may indicate the presence of communicable or non-communicable disease.**
- I may cancel this authorization at any time. This cancellation will not apply to information already released/obtained based on this authorization.
- The person or organization receiving information based on this authorization could re-release the information to others and federal law would no longer protect it. I release the hospital and its staff, employees, officers and directors from any responsibility from such re-release.
- Oklahoma Cancer Specialists and Research Institute will not base treatment, payment, enrollment in a health plan or eligibility for benefits upon getting this authorization.

**With this knowledge, I voluntarily give my consent to the use and disclosure of individually identifiable health information including information concerning my identity and release Oklahoma Cancer Specialists and its duly authorized agents and employees from any liability in connection with the use or disclosure of the information contained herein.**

Signature of Patient/Personal Representative	Date	Time	Patient/Personal Representative ID verified by: <input type="checkbox"/> Picture ID <input type="checkbox"/> Other (specify): _____
Authority of Personal Representative to act on behalf of Patient			
Reason Patient Unable to Sign			

Signature of Witness	Date	Time
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**TRANSLATION:** *This certifies that this Authorization was read to the patient or their personal representative in his/her native language; all representations that appear in the Authorization were understood and authorized by the patient or their personal representative.*

Interpreter's Signature	Date	Time
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CONFIDENTIAL INFORMATION

## Medical Record Pricing

Pricing listed below is in accordance with Oklahoma Statute 76-19(A)(2):

Patients-

Paper: \$0.50 per page

Electronic: \$10.00 base fee and \$0.30 per page and delivery fee

Attorney or Insurance via a subpoena-

Paper: \$10.00 base fee and \$0.50 per page and postage/delivery

Electronic: \$10.00 base fee and \$0.30 per page and delivery fee

Maximum fee-\$200.00

Radiology (x-ray or other images)-\$5.00

Social Security-\$18.00