OKLAHOMA CANCER SPECIALISTS AND RESEARCH INSTITUTE

AUTHORIZATION TO RELEASE OR OBTAIN INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION

Medical Record #:_____

Request Made: ☐ In Person ☐ Written

Type of Request: ☐ Release ☐ Obtain

Patient Name	Phone No.	Date of Birth	Last 4 digits Social Security No.

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

Person/Organization to release or obtain from my information (include address)

Name of Person or Organization

Street

City | State | Zip

Purpose of release/obtain:

☐ Filing insurance
☐ Continued treatment
☐ Request of patient or their legal representative
☐ Other (specify): _____

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

☐ Surgical Reports	☐ History and Physical	☐ Progress Notes	☐ Entire Chart (ALL ITEMS LISTED)
☐ Radiology Images	☐ Operative Report	☐ Treatment Plan(s)	☐ View Electronic Records
☐ Laboratory Reports	☐ Genetic Testing Results	☐ Demographics (providers only)	☐
☐ Radiology Reports	☐ Consultation Reports	☐ HIPAA Authorization	☐
☐ Pathology Reports	☐ Radiation Reports	☐ Biopsy Reports	☐ 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.
- This authorization automatically ends when the information is released or obtained
- 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: ☐ Picture ID ☐ Other (specify): _____
Authority of Personal Representative to act on behalf of Patient			
Reason Patient Unable to Sign			
Signature of Witness	Date	Time	

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

CONFIDENTIAL INFORMATION

Medical Record Pricing

Pricing listed below is in accordance with Oklahoma Statue 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