Oklahoma Heart Hospital North, South Campus, and Physicians
Oklahoma City, Oklahoma

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(Copies will be provided to a 3rd party request at $0.50 cents per page and $.30 cents, not to exceed $200 for digital form. Radiology film copies will be provided at $5.00 per sheet. Plus applicable postage and handling)

Office Use Only

DATE RECEIVED: **DATE RELEASED:**

HOSPITAL RECORDS: _____ **PHYSICIAN RECORDS:**_____ **OHH Employee:** ☐ yes ☐ no

Patient Name: _____ **Date of Birth:** _____ **Social Security #:** _____

Phone Number:_____ **Secondary Phone Number:**_____

Purpose of disclosure: ____Patient's request ____Dispute _____Treatment _____Other: _____

Date(s) of Records Requested:_____ to _____ I am the ____ Patient ____ Guardian _____ Parent ____Other

Would you like to receive the requested records in an electronic format? Yes _____ No _____ Email_____

ONLY COMPLETE IF YOU THE PATIENT IS NOT RECEIVING THE RECORDS AND THEY ARE BEING FORWARDED TO SOMEONE ELSE.

I hereby authorize **Oklahoma Heart Hospital** personnel to disclose medical information on the above named patient to: i.e attorneys name, physician, child, etc.

Please Circle or Complete Below: SELF OTHER:_____
Must Provide Name of Person Receiving Records

Below is the address of where to mail the medical records.

Address: _____

City: _____ **State:** _____ **Zip Code:** _____ **Fax #:**_____

I would like the following information:

_____ Face Sheet	_____ Emergency Room report	_____ EEG Report(s)	_____ History and Physical
_____ Operation Report(s)	_____ Pathology Report	_____ Consultation Report(s)	_____ Discharge Summary
_____ Physician's Orders	_____ Progress Notes	_____ EKG Report(s)	_____ Radiology CD
_____ Laboratory Reports(s)	_____ Radiology Report(s)		

_____ Other: _____

I understand:

- I may revoke this authorization at any time, in writing. My revocation will not apply to information already retained, used or disclosed in response to this authorization. Unless revoked, the automatic expiration date will be one (1) year from the date of signature.
- Unless the purpose of this authorization is to determine payment of a claim or benefits, OHH may not condition the provision of treatment or payment for my care on my signing this authorization.
- Information used or disclosed under this authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy regulations.
- **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE OR NON COMMUNICABLE DISEASE .**
- The information authorized for release also may include protected health information related to mental health.
- The information authorized for release also may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit anyone receiving this information or records from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below I specifically authorize any such records included in my health information to be released.

_____ _____ _____
Signature of Patient, Parent, or Legally Authorized Representative | Relationship to Patient | Date

Patient must sign unless there is a Power of Attorney or if Deceased it must be signed by the Executor of the Estate

Please Mail To: Oklahoma Heart Hospital North and Physicians
Health Information Management Department,
7800 N.W. 85th Terrace, Suite 200
Oklahoma City, OK 73132 **OR**
Fax **Hospital-** (405) 608-1557 **Physicians-** (405) 608-3838

Oklahoma Heart Hospital South Campus
Health Information Management Department,
5200 E. I-240 Service Rd
Oklahoma City, OK 73135 **OR**
Fax to (405) 628-6960

Form Revision #	Form Changes
OHHP-F497 (Rev. 6/16)	Added 3rd party request
OHHP-F497 (Rev. 10/17)	Added OHH Employee