Community Health Connection Medical Services

9912 East 21st Street Tulsa, OK 74129 | 2321 East 3rd Street Tulsa, OK 74104
Phone: 918-622-0641 Fax: 918-622-0683

AUTHORIZATION TO RELEASE/REQUEST FOR AN INDIVIDUAL'S HEALTH INFORMATION

Last Name: _____ **First Name:** _____ **Middle Name:** _____

Other Names Used: _____

Date of Birth: _____ **SSN:** _____

Address: _____

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

Home Phone: _(____)_____ **Work Phone:** _(____)_____

I hereby request access to the protected health information in my health record from (date) _____ to (date) _____ maintained or created by Community Health Connection, Inc. (CHC).

- ☐ Most Recent Progress Notes
- ☐ Pathology/Lab Reports
- ☐ X-ray Reports/Films
- ☐ Discharge Summaries
- ☐ Billing Records
- ☐ Immunization Records
- ☐ Dental Records
- ☐ Entire Health Record* (Excludes Psychotherapy Notes)
- ☐ Other: _____
- ☐ Psychotherapy Notes* (if checking this box, no other boxes may be checked. A separate Authorization to Release/Request for an Individual's Health Information must be completed to obtain additional records)

- ☐ I will pick up copies of my records
- ☐ Mail copies of my records to the individual noted below
- ☐ Fax my records to: _____

Records From:	Records To:
Name:	Name:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

[File in Patient Chart]

HIPAA Document
Retain for Minimum of 6 years

Purpose of Request: ☐Patient's Request ☐Dispute ☐Referral ☐Other: _____

I understand:

- I may revoke this Authorization at any time by providing my written revocation to the address at the top of this form. My revocation will not apply to information already retained, used, or disclosed in response to this Authorization. Unless sooner revoked, the automatic expiration date of this Authorization will be twelve (12) months from the date of signature.
- Unless the purpose of this Authorization is to determine payment of a claim or benefits, CHC may not condition the provision of treatment or payment for 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 RECORDS THAT MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR NONCOMMUNICABLE DISEASE.**
- *The information authorized for release may include protected health information related to mental health. Release of mental health records or psychotherapy notes may require consent of the treating provider or a court order.
- The information authorized for release may include drug/alcohol abuse treatment records. This category of medical information/records is protected by Federal confidentiality rules (42 C.F.R. Part 2). The Federal rules prohibit anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the person to whom it pertains or is otherwise permitted by 42 C.F.R. 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.

_____(Initial) I understand that if my records are released, I will be charged $1.00 for the first page, $0.50 for each subsequent page for paper records, and $5.00 per x-ray, image, or slide, plus postage, **payable prior to the release** of the requested records. These fees have been set by the Oklahoma legislature.

_____	_____	_____
Signature of Patient, Parent, or Legal Authorized Representative**	Relationship to Patient	Date

**May be requested to show proof of representative status

For Office Use Only

Date Received: _____ **Date Sent:** _____ **Processor:** _____

[File in Patient Chart]

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