

**Authorization to Release/Request for an Individual's Health Information**

Last Name: \_\_\_\_\_ First: \_\_\_\_\_ Middle: \_\_\_\_\_

Other Names Used: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: \_\_\_\_\_

Member ID#: \_\_\_\_\_

I hereby request access to the protected health information in my health record from (date) \_\_\_\_\_ to (date) \_\_\_\_\_ maintained or created by the University Employee Health Plan to the recipient named below.

- 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.)
- Entire Health Plan Record \*(Excludes Psychotherapy Notes)
- Billing Records
- Other \_\_\_\_\_

**Provide Records To Recipient:**

Name: _____		
Address: _____		
City: _____	State: _____	Zip: _____
Fax: _____	Phone: _____	

Purpose of Request:  Member'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 bottom of this form. My revocation will not apply to information already retained, used, or disclosed under this Authorization. Unless sooner revoked, the automatic expiration date of this Authorization will be \_\_\_\_\_ months from the date of signature (12 months, if none entered).
- Unless the purpose of this Authorization is to determine payment of a claim or benefits, the Health Plan 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 law.
- The information authorized for release may include substance use disorder records.
- \*The information authorized for release may include protected health information and/or student treatment/education records 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 CFR 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 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 Member. As a result, by signing below, I specifically authorize any such records included in my health information to be released.
- I agree that costs for records are as follows and are payable prior to the release of the requested records (initial one):
  - \_\_\_\_\_ Paper Format – 50 cents per page, plus postage
  - \_\_\_\_\_ Digital Format – 30 cents per page plus the cost of the digital media (disk, flash drive, etc.), plus postage
  - \_\_\_\_\_ X-ray Film - \$5 per x-ray film, plus postage(Releases in response to subpoenas or requests by attorneys, and insurance companies are charged an additional \$10 fee.) Make checks payable to Cameron University. These fees were set by the Oklahoma legislature.

- I will pick up copies of my records
- Fax my records to: \_\_\_\_\_
- Mail copies of my records to the individual noted below
- Provide my records in electronic form: (CD, flash drive) if available: \_\_\_\_\_

I understand the security of email cannot be guaranteed and that unauthorized individuals may be able to access the message. I understand the information sent via electronic communication may include information that may indicate the presence of a communicable disease or non-communicable disease, mental health records, or substance use disorder records. It is my responsibility to notify Cameron Health Plan if the email address information changes after submitting this form. **I understand and agree to the statements above and wish to have my records sent to the Recipient via email at:** \_\_\_\_\_@\_\_\_\_\_.

Signature of Member, Parent, or Legal Authorized Representative\*\*      Date:

\*\*May be requested to show proof of representative status