

**Cameron University
Health Plan**

Authorization to Release Protected Health Information Verbally to Others

Last Name: _____ First: _____ Middle: _____
 Member ID #: _____ Birthdate: _____
 Address: _____ City: _____ State: _____ Zip: _____
 Home Phone: _____ Alt. Phone: _____ Cell Phone _____

I _____ give my permission to: Cameron's Health Plan

to release **verbally** information regarding my protected health information checked below that the Health Plan created or maintained from (date) _____ to (date) _____:

Verbally Release My Information to:			Verbally Release My Information to:		
Recipient Name:			Recipient Name:		
Relationship to Patient:			Relationship to Patient:		
Address:			Address:		
City:	State:	Zip:	City:	State:	Zip:
Fax:	Phone:		Fax:	Phone:	
Exceptions:			Exceptions:		

• Purpose of Request: referral legal transfer other: _____

• This authorization to release Protected Health Information **verbally** applies to discussions about information from my:

- Entire Health Record*
Excludes Billing Records/Notes and Psychotherapy Notes
- Entire Health Record plus Billing Records/Notes*
Excludes Psychotherapy Notes*
- Psychotherapy Notes* (if checking this box, no other boxes may be checked. A separate copy of this form must be completed to obtain any other types of records.)

OR only these portions of my record:

- X-ray Reports/Films
- Immunization Records
- Discharge Summaries
- Medications
- Pathology/Lab Reports
- Billing Records
- Other: _____

I understand:

- I may revoke this Authorization at any time by providing my written revocation to the Health Plan named in the upper left-hand corner or the University Privacy Official at the University of Oklahoma Health Sciences Center, P.O. Box 26901, Oklahoma City, OK 73129. 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 _____ 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.
- The information used or disclosed under this Authorization may be subject to re-disclosure by the recipient and no longer protected by federal privacy laws.
- The information authorized for release may include substance use disorder records. This category of medical information/records is protected by Federal confidentiality rules (42 CFR Part 2). A general authorization for the release of medical or other information is not sufficient for this purpose. As a result, by signing below, I specifically authorize any such records included in my health information to be released. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. 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.

Signature of Patient, Parent, or Authorized Legal Representative**

Relationship to Patient

Date

**May be requested to show proof of representative status