

Oklahoma Cardiovascular Associates

Authorization for the Release of Health Information

OCA Releasing Records
Please fax back to: (405) 608-3838

I hereby authorize Oklahoma Cardiovascular Associates to disclose my individually identifiable health information as described below.

Patient Name	Social Security Number	Date of Birth

Name of person(s) or organization(s) requesting records, if different than Patient:

Name & address of person(s) or organization(s) to **receive** records:

Information Requested (please initial)

I am requesting the following records from the patient's medical records that were created between ___/___/___ and ___/___/___.

- Hospital Records Generated by OCA physician
- Lab Results
- Physician Correspondence
- Physician Office Notes
- Testing Reports
- Other

Purpose for which records will be used: _____

Legal Authority for Request (please initial)

- I am the Patient noted above.
- I am the Patient's attorney-in-fact, and I have attached to this authorization a valid Power of Attorney or Durable Power of Attorney for Health Care (DPAHC) that grants me the power to request the Patient's medical records. If a DPAHC is attached, then I have also included evidence that the Patient's attending physician has determined that the Patient has lost the capacity to make informed health care decisions.
- I am the Patient's legal guardian and I have attached to this authorization a valid Appointment of Guardianship from a probate court.
- If the Patient is deceased: I am the Executor/Administrator of the Patient's Estate, and I have attached to this authorization a valid appointment as such from a Probate court or a copy of a death certificate stating I am next of kin.
- The Patient has executed a legally binding instrument granting me the authority to obtain his/her medical records and I have attached a copy of that instrument to this authorization.
- The Patient's legally authorized representative has executed a legally binding instrument granting me the authority to obtain the Patient's medical records. I have attached a copy of the instrument granting me such authority, as well as evidence that the person who executed that instrument had the legal authority to do so, e.g., a Power of Attorney or Probate court order.

I understand the following:

- **OCA may not condition treatment on my providing this authorization for use or disclosure of my medical information. If I refuse to sign this authorization, I will still be eligible to receive medical services from OCA.**
- **I have the right to revoke this authorization at any time by sending a letter to the OCA Privacy Officer which gives my name and the date I signed this authorization, and states that I revoke the authorization to use my medical information.**
- **If OCA discloses this information as permitted by HIPAA, the recipient could possibly later use or disclose the information without my authorization.**
- **I may inspect or copy the information from my medical records that will be used by OCA for the purposes set forth in this authorization.**
- **I will receive a signed copy of this authorization form if requested.**
- **This authorization expires two years after the date it is signed.**

My medical information may indicate that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

Understandings & Agreements of Requestor

1. **This agreement is voluntary.**
2. This authorization will expire on the following date: _____ Patient Initials _____
3. I understand that I may revoke this authorization at any time by notifying the Oklahoma Cardiovascular Associates in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation.
4. I agree to waive all claims against Oklahoma Cardiovascular Associates for the release of the requested information.
5. I understand that once the information described herein is disclosed, it may no longer be subject to the privacy protections afforded by Oklahoma Cardiovascular Associates if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or a business associate that has a contract with the facility.
6. I understand that I must provide Oklahoma Cardiovascular Associates with at least 24 to 48 hours notice before coming to the facility to review/retrieve the records.
7. I understand that after I have reviewed the records, I must provide Oklahoma Cardiovascular Associates with advance notice of any copies of the records that I would like to pick up at the facility.
8. I understand that if I request that records be copied and sent to me that Oklahoma Cardiovascular Associates will make a good faith effort to send those records to me in a reasonable amount of time.
9. I understand that if I wish to have copies of records made, then Oklahoma Cardiovascular Associates may assess a fee for copying the records, which has been set by Oklahoma law (a) \$1.00 for the first page and .50 cents for every page thereafter; (b) \$5.00 for each x-ray or other photo image; and (c) \$10.00 for CD production for digital x-ray and ultrasound; and (d) the actual cost of any postage to send certified copies.

Signature of person making request

Date

Printed Name of person making request