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| ou-logo | **The University of Oklahoma**Insert Entity Here |

**Authorization to Verbally Release**

**Protected Health Information**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Last Name: |  | First: |  | Middle: |  |
| Other Names Used: |  | Date of Birth: |  |
| Address: |       City: State: |
| Home Phone: | (     )       | Work Phone: | (     )       |

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| --- | --- | --- |
| I |  | give my permission to: |
|  |
| Name of Physician, Provider, and/or Department/Clinic |

to release verbally information regarding appointment dates/times and my protected health information (or, if I am a student, my treatment/education record) from (date) \_\_\_\_\_\_\_ to (date) \_\_\_\_\_\_\_ maintained or created by the provider named below to the recipient named below. (If applicable, the student’s dates of enrollment are \_\_\_\_\_\_\_ to \_\_\_\_\_\_\_.)

This Authorization applies to \_\_\_\_\_ my complete medical record OR \_\_\_\_\_ my psychotherapy notes OR \_\_\_\_\_ only this information:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Verbally release to:

Name of Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Entity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Entity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exceptions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exceptions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand that:**

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 12 months from the date of the signature.

* Unless the purpose of this Authorization is to determine payment of a claim or benefits, the provision of treatment or payment for my care may not be conditioned upon my signing of 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. Student treatment/education records may retain continuing privacy protections in accordance with 34 CFR Part 99.
* **THE INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE INFORMATION WHICH MAY INDICATE THE PRESENCE OF A COMMUNICABLE DISEASE OR A NONCOMMUNICABLE DISEASE.**
* The information authorized for verbal 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 verbal 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 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.

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|  |  |  |  |  |
| Signature of patient, Parent, or Legally Authorized Representative | **\***Relationship to Patient |  Date |

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