Patient Request for Medical Records / "Protected Health Information (PHI)"

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Home Phone:	Cell Phone (optional):	
Street Address:	City:	State:	Zip:

What records do you want? (Check appropriate boxes below):

Date(s) of Service:_____/____/____through_____/____/_____

☐ Clinic Notes
☐ Operative Reports
Other (please specify):_____

Please note: for x-rays taken at the office, please call 405-692-9300 option 0. For any other imaging studies (CT, MRI, etc.), you will need to contact the facility at which the imaging was obtained.

Please provide my records to: ☐ Self ☐ Person/Organization Specified Below

Recipient Name:	Recipient Phone:
Recipient Email Address or Mailing Address:	Recipient Fax (For Patient Care Only):

Please initial the items below to indicate your understanding and provide your consent as applicable:

_____ Please note that federal law now prohibits medical practices from sending you email or texts that are unencrypted as they consider this "unsecured". Some patients appreciate the trade off between security and easy, fast, effective communication. Even though the office side of the record transmission is HIPAA compliant via an "encrypted" or "secure" email client, electronic mail ("email") messages and their attachments in transit could potentially be read by a third party or stored by a third party. In the interest of facilitating easy communication, I acknowledge this risk and provide my free and voluntary consent to hold harmless all parties responsible for providing these records to me or to those whom I authorize here. I request the records via non-encrypted means.

_____ I understand that the information in my health record may include information related to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.

_____ I understand that once the information below is released, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations.

_____ I understand that I have a right to revoke this authorization at any time. I understand if I revoke this authorization, I must do so in writing and present my written revocation to the practice. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

_____ I understand that authorizing the use or release of this information is voluntary. I need not sign this form to ensure health treatment.

Name of Patient (please print)

Name of Personal Representative (please print)	**Relationship to the Patient (please print)**
Signature of Patient or Personal Representative	**Date**

Please return this completed form to:

Dr. Hogan's office staff
Email: clinic@okcspineortho.com
Questions? 405-486-6820

There may be charges associated with processing a request and producing requested records pursuant to 45 CFR164.524(c)(4)