HIPAA FORMS

Updated 3/03

Policy #	HIPAA Privacy Policy	Form #	HIPAA Document
04.	Notice of Privacy Practices	04	Notice of Privacy Practices Acknowledgement and Consent
05.	Patient Access to Protected Health Information	05.A	Individuals Request for PHI
		05.B	Denial of Individual's Request for PHI
06.	Accounting of Disclosures	06.A	Request for Accounting of Disclosures
		06.B	Accounting of Disclosures Form
07.	Communication by Alternative Means	07	Request for Alternative Means of Communication
08.	Right to Amend Records	08.A	Request for Amendment of PHI (pg 1 & 2)
		08.B	Amendment Acceptance – Notification Form
09.	Right to Request Restriction on Disclosures	09	Request for Restrictions on Use and Disclosures
10.	Privacy Official – Contact Information	10	Privacy Official – Contact Information
11.	Privacy Complaint Reporting and Tracking	11	Health Information Privacy Complaint Form
18.	Safeguards	18	Fax Cover Sheet (faxing PHI)
21.	Minimum Necessary Rule	21	Employee Role Based Access Worksheet
23.	Authorization	23	Authorization Form For Uses & Disclosure of Patient PHI (pg 1 & 2)
25.	Required by Law	25	Requirements for Content and Service of a Subpoena (pg 1 & 2)
27.	Business Associates	27	Business Associate (BA) Decision Chart
30.	Research	30.A	Research on Decedent's Information Request Form
		30.B	Reviews Preparatory to Research Request Form
		30.C	Training and Education Release Form
33.	Facility Directory	33	Directory Opt-Out Form

NOTICE OF PRIVACY PRACTICES
ACKNOWLEDGEMENT AND CONSENT

ACKNOWLEGEMENT OF NOTICE OF PRIVACY PRACTICES:

The Notice of Privacy Practices tells you how we may use and share your health records. **Please read it.**

- We will use and share your health records to treat you and to bill for the services we provide.
- We will use and share your health records to run our business.
- We will use and share your health records as required by law.

All the ways we may use and share your health records are explained in more detail in the Notice of Privacy Practices.

You have the following rights with respect to your health records:

1. You have the right to look at and receive a copy your health records.
2. You have the right to receive a list of whom we have given your health records to.
3. You have the right to ask for us to correct a mistake in your health records.
4. You have the right to ask that we not use or share your health records.
5. You have the right to ask us to change the way we contact you.

All of these rights are explained in more detail in the Notice of Privacy Practices.

I have received a copy of the University's Notice of Privacy Practices.

Signature:_____________________________________ Date:____________________
(of Patient or Legal Representative)

Capacity of Legal Representative (if applicable)*:________________________________

CONSENT:

I **consent** to the use and sharing of my health records for treatment, payment, and operation purposes as described in the Notice of Privacy Practices. I know that if I do not consent, you cannot provide services to me.

Oklahoma law requires that we advise you that the **information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to, Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus and Acquired Immune Deficiency Syndrome (AIDS). It also may include mental health or other sensitive information.**

Signature:_____________________________________ Date:____________________
(of Patient or Legal Representative)

Capacity of Legal Representative (if applicable)*:________________________________

*May be requested to provide verification of representative status.

The University of Oklahoma
HEALTH SCIENCES CENTER

Office Use Only

MRN________________

Individual's Request for Protected Health Information

PATIENT

NOTICE TO PATIENT: Your request for access to your protected health information **only** is applicable to the information maintained by by the University of Oklahoma. If you would like access to your protected health information maintained by any other Health Care Provider, a separate request must be submitted to that provider. (This request is **only applicable to OKC: including those hospitals referred to as the OU Medical Center.**)

Last:______________________________________ **First:**______________________________ **Middle:**____________________

Other Names Used:______________________________**Date of Birth**:_______________ **SS #:** __________________________

Address:____

Hm Phone: (____)__________________________________ **Wk Phone:** (____)_____________________________________

Release FROM:

I hereby request access to the protected health information in my designated record set from____ to ____________________________________ maintained or created by the following providers associated with the University of Oklahoma:

Name of Physician or Other Provider	Department / Clinic

I hereby request access to the following information maintained or created by the providers listed above.

I agree to be billed $.25 per page for paper records and $5.00 per film for radiology films, plus postage for releasing the requested records. Invoice will be mailed directly to Patient/Parent/Legal Guardian at the address provided above.

[ ] Patient History
[ ] Information created or received from other providers.
Specify which ones or all:_________________________________
[ ] Hospital and consulting physician summaries
[ ] Billing Records
[ ] Entire Designated Record Set
[ ] Other ____

[ ] Shot records only
[ ] Lab Reports
[ ] X –rays
[ ] Radiology Reports
[ ] Pathology Reports

Release TO:

[ ] I will pick up the copies of my records.
[ ] Mail copies of my records to:
____ Myself ____ Legal Representative

[ ] **Access Granted or**
[ ] **Copy sent**
on ___________________________
Date

Name: ____

Address:____

Phone #:____ Fax #: ____

The information authorized for release may include records which indicate the presence of a communicable or venereal disease including, but not limited to, hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome ("AIDS") and/or mental health information.

The information authorized for release also may include records related to mental health and/or substance abuse treatment.

I understand this authorization is only valid ninety (90) days from the date of the signature below

____ ___________________________________ ________________________

Signature of Patient, Parent, or Legal Guardian **Relationship to Patient** **Date**

The University of Oklahoma
HEALTH SCIENCES CENTER

Denial of Individual's Request for Protected Health Information

Date: ______________________ Patient MR #: ______________________

Patient Name: ____

Patient Address: ______________________________ ______________________
Street Apt # City State Zip

The request you submitted for access to your protected health information maintained in a designated record set by ____ has been **denied**, in whole or in part, for the reason indicated below:

[ ] **1. Information Not Available:** We do not have the information you requested. The information you requested can be obtained from: ______________________________ (Alternative location will be provided, if known.)

[ ] **2. Legal Information:** All, or a portion of, the information you requested has been compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding.

[ ] **3. Inmate Information:** Releasing a **copy** to you would jeopardize the health, safety, security, or rehabilitation of you or other inmates, or the safety of any officer, employee, or other person at the correctional institution or who is responsible for your transportation.

[ ] **4. Research:** As you agreed by signing a research participation consent form, your access to the protected health information created or obtained in the course of the research has been temporarily suspended. The suspension will last for as long as the research is in progress.

[ ] **5. Information from Other Source:** The information you are requesting was obtained from someone under a promise of confidentiality and the access requested would be reasonably likely to reveal the source of the information.

[ ] **6. Endangerment:** A licensed health care professional has determined that the access you requested is reasonably likely to endanger the life or physical safety of you or another person. *You may request a review of a denial for this reason*.

[ ] **7. Reference to Other People:** The information you requested makes reference to another person and a licensed health care professional has determined, in the exercise of professional judgment, that the access requested is reasonably likely to cause substantial harm to such other person. *You may request a review of a denial for this reason.*

[ ] **8. Personal Representative:** A licensed health care professional has determined that the provision of access to the information you requested is reasonably likely to cause substantial harm t the individual or another person. *You may request a review of a denial for this reason.*

[ ] **9. Psychotherapy Notes:** Your treating health care provider has not approved the release of your psychotherapy notes**.**

Information that is not subject to one of the reasons for denial listed above will be provided to you as requested.

Right to Review:

If a right to review is available as indicated in the fifth, sixth and seventh(5th, 6th, and 7th) reasons set forth above, you may request a review of the denial from the health care provider who denied your initial request. Your request Will be reviewed by the Medical Director for OUHSC within thirty (30) days after receiving the request for review.
The determination of the Medical Director will be Final. You will be notified promptly, in writing, of the Medical Director's decision.

Complaints:

You may file a complaint regarding the University's compliance with the HIPAA Privacy Regulations with the Secretary of the Department of Health and Human Services or any other agency that has been delegated the responsibility to enforce the Privacy Regulations. You may also submit a complaint to the University's Privacy Official by calling (405) 271-2511 or sending an e-mail to OU-Privacy@ouhsc.edu. You may also submit an anonymous complaint by calling the University's Compliance Hotline, (405) 271-2223 or 1-866-836-3150.

The University of Oklahoma
HEALTH SCIENCES CENTER

Request for Accounting of Disclosures

Patient Name: ____ **Date of Birth:** ________________

Patient SS #: ____________________ **Patient MR #:** ______________ **Patient Acct #:** _______________

Address where you want the accounting sent: ____

____

NOTICE TO PATIENT:
Your request for an accounting of disclosures of your Protected Health Information **only** is applicable to the information maintained by the University of Oklahoma. If you would like to request an accounting of disclosures of your protected health information from any other Health Care Provider, a separate request must be submitted to that provider. **(This request is only applicable to OKC: including those hospitals referred to as the OU Medical Center.)**

REQUEST FOR ACCOUNTING OF DISCLOSURES:

I request an accounting of disclosures of the protected health information in my designated record set from _________________________________ to _______________________________ (not to exceed 6 years) maintained or created by the following providers associated with the University of Oklahoma.

Name of Physician or Other Provider	Department / Clinic

I understand that the first accounting in a twelve (12) months period is free of charge, but that I can be charged a reasonable fee for any additional accountings.

I understand that the accounting must include all disclosures, <u>except</u> for disclosures.

1. to carry out treatment, payment and health care operations;
2. to individuals of protected health information about them;
3. incident to a use or disclosure permitted by the Privacy Regulations;
4. pursuant to the individual's authorization;
5. to persons involved in the individual's care or for a facility directory;
6. for national security or intelligence purposes;
7. to correctional institutions or law enforcement officials to provide them with information about a person in their custody;
8. as part of a limited data set; or
9. that occurred prior to the compliance date.

____
Signature *** Title, if legal representative** **Date**

* May be requested to submit evidence of representative status.

The University of Oklahoma
HEALTH SCIENCES CENTER

Accounting for Disclosures Form

NOTICE: Check with Legal Counsel prior to making any non-routine disclosures.

Patient Name: ____ **Date of Birth:** ________________

Patient SS #: ____________________ **Patient MR #:** ______________ **Patient Acct #:** _______________

PHI – Protected Health Information

Date of Disclosure	Name and Address (if known) of Entity Receiving PHI	Description of PHI Disclosed	Statement of Purpose of Disclosure

The University of Oklahoma
HEALTH SCIENCES CENTER

Request for Alternative Means of Communication

Patient Name: ________________________________ Date of Birth: _______________ MR #:__________________

Patient Address: ____
Street Apt # City State Zip

Patient Hm Phone #: (___)__________________________ Patient Wk Phone #: (____)_______________________

NOTICE TO PATIENT: Your request for communication by alternative means is applicable **only** to the information maintained by the University of Oklahoma. If you would like communications maintained by any other Health Care Provider, a separate request must be submitted to that provider. **(This request is only applicable to OKC: including those hospitals referred to as the OU Medical Center.)**

My request for alternative means of communication applies to the following providers associated with the University of Oklahoma:

Name of Physician or Other Provider	Department / Clinic

REQUESTED ALTERNATIVE MEANS OF COMMUNICATION:

[ ] Alternative Phone Number: (__)____

[[Alternative Mailing Address: ____

[ ] Other Alternative Means of Communication: _________________________________

My request applies to:

[ ] Communications about this date of service only (indicate date) ___________________________ , or

[ ] Communications from this date of service (indicate date) ________________________ until I indicate otherwise, or

[ ] From ____________________ To ____________________________

____

Signature *** Title, if legal representative** **Date**

* May be requested to submit evidence of representative status

☐ **Request APPROVED** ☐ **Request DENIED**

BY:____
Signature Title Date

Reason for Denial: [ ] Too expensive to accommodate request.
[ ] Administratively impractical to accommodate request.
[ ] You failed to provide information as to how payment, if applicable, will be handled.
[ ] You failed to specify an alternative address or method

Additional Explanation:____

Request for Amendment of Protected Health Information

NOTICE TO PATIENT: Your request for an amendment to your protected health information **only** is applicable to the information maintained by the University of Oklahoma.. If you would like to request amendments to your protected health information maintained by any other Health Care Provider, a separate request must be submitted to that provider. **(This request is only applicable to OKC: including those hospitals referred to as the OU Medical Center.)**

Patient Name: ______________________________ **Date of Birth**: ______________ **MR #:**__________________

Patient Address: ____
Street Apt # City State Zip

Address where you want the amendment response sent:

____

____

REQUESTED AMENDMENT:

Date of the record or information you would like amended: ____

I request that you amend (describe the information you would like amended): ________________________________

____

____

I would like this information amended because (state specific reason for amendment):_________________________

____

I request the amendment described above to be made to the protected health information in my designated record set maintained or created by the following providers associated with the University of Oklahoma:

Name of Physician or Other Provider	Department / Clinic

____

Signature *** Title, if legal representative** **Date**

* May be requested to submit evidence of representative status.

The University of Oklahoma
HEALTH SCIENCES CENTER

Request for Amendment of Protected Health Information

[ ] Request APPROVED

If we approve your request for amendment, please complete the attached form, 08.B Amendment Acceptance – Notification Form, and return it to us, to identify any persons or entities that we need to notify of the amendment to your protected health information.

[ ] Request DENIED

by:____

Signature Title Date

Reason for Denial:

[ ] The information was not created by the physician or clinic to which you submitted the request.

[ ] The information is not part of your Designated Record Set.

[ ] The information is not available for your inspection pursuant to the University's Policy regarding individual access because ____.

[ ] The information is accurate and complete.

If Denied:

If you do not submit a written statement disagreeing with the denial, you may request, in writing, that we provide your request for amendment and our denial with any future disclosures of the protected health information that is the subject of your request. This request should be submitted to us within sixty (60) days of receiving the notice of denial.

You may make a complaint to the University's Privacy Official regarding the denial of your amendment. The contact information for the University's Privacy Official is:

Direct Line: (405) 271-2511

Anonymous Hotline: (405) 271-2223 or 1-800-836-3150

E-mail: OU-Privacy@ouhsc.edu

You also may submit a complaint to the Secretary of the Department of Health and Human Services regarding the denial of your amendment. The complaint must be written, but can be submitted either on paper or electronically. A complaint must name the entity that is the subject of the complaint and describe the acts or omissions believed to be in violation of the HIPAA Privacy Regulations. You must submit the complaint within 180 days of when you knew or should have known that the act or omission complained of occurred.

Amendment Acceptance Notification Form

I request and authorize ______________________________ **to notify the**
name of clinic/department/provider

health care providers or entities listed below of the amendment(s) to the medical records of:

____.
name of patient

Signed:____
Name Title, if legal representative Date

Providers / Entities that Need to be Notified of Amendment:

Name:______________________ **Name**:______________________
Clinic:______________________ Clinic: ______________________
Address:______________________ Address:______________________
______________________ ______________________

Name:______________________ **Name**:______________________
Clinic:______________________ Clinic: ______________________
Address:______________________ Address:______________________

Name:______________________ **Name**:______________________
Clinic:______________________ Clinic: ______________________
Address:______________________ Address:______________________
______________________ ______________________

OFFICE USE:

Name / Title of person who completed request: ______________________

Date Request Completed: ______________________

ROUTE TO:
[ ] Billing
[ ] ___________
[ ] ___________

Request for Restrictions on Use and Disclosures of Protected Health Information

NOTICE TO PATIENT: Your request for a restriction on the use and disclosure of your protected health information **only** is applicable to the information maintained by the University of Oklahoma. If you would like to request a restriction on the use and disclosure of your protected health information maintained by any other Health Care Provider, a separate request must be submitted to that provider. **(This request is only applicable to OKC: including those hospitals referred to as the OU Medical Center)**,

Patient Name: ______________________________ Date of Birth: ______________________________

Patient MR #: ______________________________ Social Security #: __________________________

Patient Address: ____

Address City State Zip

I hereby request on the use and/or disclosure of my protected health information maintained or created by the following providers associated with the University of Oklahoma:

Name of Physician or Other Provider	Department / Clinic

REQUESTED RESTRICTION: Check the box to indicate the type of restriction and then describe the specific restriction. **Note:** Even if a requested restriction is granted, it cannot prevent complete disclosures to the individual or as required by law.

[ ] Treatment: ____
[ ] Payment: ____
[ ] Health Care Operations/Administrative Purposes: ______________________________
____
[ ] Disclosures to family member or others involved in my care: ______________________
____

My request applies to: **Check one and indicate date(s)**

[ ] Communications about this date of service only (indicate date)__________________________ **or**
[ ] From this date of service (indicate date) _____________________ until I indicate otherwise **or**
[ ] From this date _______________________ to this date _________________________

____
Signature *** Title, if legal representative** **Date**

* May be requested to submit evidence of representative status.

[ ] REQUEST APPROVED

[ ] REQUEST DENIED
[ ] Too expensive to accommodate request
[ ] Administratively impractical to accommodate request
[ ] May prevent effective treatment
[ ] Additional explanation: _______________________

By: ____
Signature Title Date

Privacy Official – Contact Information

Director of Compliance
University of Oklahoma
Health Sciences Center
Post Office Box 26901
Oklahoma City, Oklahoma 73190
Bird Library, Room 175D
(405) 271-2511

Questions and complaints can be directed to the following dedicated e-mail address: OU-Privacy@ouhsc.edu

Health Information Privacy Complaint Form

Patient Name: ______________________________ Date: ______________________

Patient Identification Number: ____

Street Address:____

City: __________________________ State: ___________________ Zip: _________

Please describe the nature of the complaint:

____

____

____

Date of Occurrence: ____________ **Information Affected:** ________________________

Please list possible recipients of protected health information:

Name	Organization
______________________	______________________
______________________	______________________
______________________	______________________

Patient Signature:_____________________________ **Date**: _____________________

Please mail this form to the University's Privacy Official at the following address:

Director of Compliance
University of Oklahoma
Health Sciences Center
Post Office Box 26901
Oklahoma City, Oklahoma 73190

You may also contact the Privacy Official by : **E-mail at: OU-Privacy@ouhsc.edu or**
Telephone: (405) 271-2511

FAX
COVER SHEET

Protected Health Information

Confidential Health Information Enclosed

Health care information is personal and sensitive. It is being faxed to you after appropriate authorization from the patient or under circumstances that do not require patient authorization. You, the recipient, are obligated to maintain this information in a safe, secure and confidential manner. Re-disclosure without additional patient consent or authorization or as permitted by law is prohibited. Unauthorized re-disclosure or failure to maintain the confidentiality of this information could subject you to penalties under Federal and/or State law.

Date Transmitted: _____________ **Time Transmitted**: ___________ **# of Pgs (including cover sht)**:_______

Intended Recipient: ____

Facility: ____

Address: ____

Phone # :______________________________________ **Fax #** : ___________________________________

Documents being Faxed: [ ] Clinic Records [ ] PT [ ] Lab [ ] X-Ray
[ ] Other____

Verification of Transmission of Particularly Sensitive Health Information

I verify the receiver of this Fax has confirmed its transmission:

Name:____________________________ Date:____________________ Time: ______________________

I verify that I have confirmed the receipt of this Fax transmission by phone:

Name:____________________________ Date:____________________ Time: ______________________

Please contact ____
at ____
to verify receipt of this Fax or to report problems with the transmission.

* * Confidentiality Statement * *

The information contained in this facsimile transmission is privileged and confidential and is intended only for the use of the recipient listed above. If you are neither the intended recipient or the employee or agent of the intended recipient responsible for the delivery of this information, you are hereby notified that the disclosure, copying, use for distribution of this information is strictly prohibited. If you have received this transmission in error, please notify us immediately by telephone to arrange for the return of the transmitted documents to us or to verify their destruction.

Attach this transmission verification to the Release of Protected Health Information

The University of Oklahoma
HEALTH SCIENCES CENTER

Employee Role Based Access Worksheet

Name: ______________________________ **Date :** ______________

Job Title: ______________________________ **Employee ID #:** ______________

College/Department/Clinic: ______________________________

Supervisor: ______________________________

PHI = Protected Health Information	**Type of Use – check those that are applicable**							
Type of PHI Employee Needs Access To	**No Access**	**Create**	**Edit**	**Use**	**View**	**Disclose**	**Transport**	**Destroy**
Individual will not need access to **PHI** in order to do their job.								
Entire Designated Record Set								
Progress Notes								
Facility Directory (George Nigh)								
Demographics								
Financial								
Medication Orders								
Lab Orders								
Radiology Orders								
Ancillary or Other Orders								
Ancillary Results								
Lab Results								
Radiology Results								
Physician Dictation								

TYPE OF USE:
Create or Add to: Primary source of documentation and/or make entries under the direction of the provider.
Edit: Changing incorrect data and/or transcribing data.
Use: Read to make decisions appropriate for your position.
View: Employee position requires them to view information but is not expected to make decisions.
Disclose: Conveyance of the information to persons or entities outside of the practice.
Transport: Moving information from one place to another.
Destroy: Final legal disposition of the records.

I understand that my access to, and use of, protected health information created, obtained, or maintained by the university is limited to the types and uses indicated in this worksheet. I agree to seek permission from my supervisor prior to using protected health information in any manner not permitted by this worksheet.

I understand that if I use or disclose protected health information in violation of this worksheet, the University's Privacy Policies, or the federal or state privacy laws, I will be subject to sanctions, up to and including termination.

______________________________ ______________________________

Employee Signature **Supervisor**

The University of Oklahoma
HEALTH SCIENCES CENTER

Authorization Form

For Uses and Disclosures of Patient Health Information

Name: ____ **Date of Birth:** _______________________

I hereby authorize

____

Insert the specific name of the Health Care Component or University Personnel

to release the protected health information indicated below to:

Name:____ Phone Number: _________________________

Address: ____

Requested Information:

I authorize the disclosure of the following types of records created from _____________ to _____________:

Note: You will be charged $.25 per page for paper records and $5.00 per film for radiology films.

[ ] Billing Records

[ ] Lab Reports

[ ] Pathology Reports

[ ] Radiology Reports

[ ] X-rays

[ ] Other___________________________________

[ ] Information created or received from other providers. (Specify which ones or “all”)

____

[ ] Entire designated record set

Purpose of the Requested Use or Disclosure:

The purpose of the use or disclosure is:

[ ] At the request of the patient or

[ ] Other (indicate specific reason)____

Expiration Date

This authorization will automatically expire:

[ ] ________________ (May not exceed 12 months from the date of the signature below.) **or**

[ ] When the following event occurs: ____

The University of Oklahoma
HEALTH SCIENCES CENTER

Authorization Form

For Uses and Disclosures of Patient Protected Health Information

---

Please Note the Following:

You may refuse to sign this authorization. Your refusal will not affect your ability to obtain treatment or payment.

1. If the persons or entities who are authorized to receive the information above are not health care providers or health plans covered by federal health privacy laws, they may redisclose the information and those laws would no longer protect the disclosed health information.

2. Once you sign this authorization, we can rely on it until you revoke it or, if you have not revoked it, until it expires. You can revoke this authorization by delivering a dated and signed letter to our clinic addressed to:

   ____

3. at the following address: ____

4. The information authorized for release may include records which indicate the presence of a communicable or venereal disease including, but not limited to, hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome ("AIDS") and/or mental health information.

5. [ ] if checked, we will receive compensation for our use/disclosure of the information that is the subject of this authorization.

Signature:____ **Date**:________________________________

Patient or Legal Representative

Capacity of * Legal Representative (if applicable):____

* May be requested to provide verification of representative status.

The University of Oklahoma HEALTH SCIENCES CENTER

Requirements for Content and Service of a Subpoena

Upon receipt of the subpoena, legal counsel must evaluate the document to determine whether it is valid on its face and whether it was properly served.

Validity of the Subpoena

A valid Oklahoma state court subpoena must contain the following:

- The name of the court in which the proceeding is being held.
- The names of the plaintiff(s) and defendant(s) in the action.
- The docket number of the case (not required in a state criminal proceeding).
- The date, time and place of the requested appearance.
- The specific documents sought by the subpoena.
- The name and telephone number of the attorney who caused the subpoena to be issued (not required in a state criminal proceeding).
- The signature or stamp and seal by the Clerk of the Court issuing the subpoena.
- In the case of a state grand jury or state criminal case involving a subpoena from a county other than Oklahoma County, the signature of the Judge.

A valid federal court subpoena must contain:

- The name of the court from which it is issued.
- The title of the action.
- Name of the court in which it is pending.
- The civil action number.
- Command each person to whom it is directed to attend and give testimony or to produce and permit inspection and copying of designated books, documents or tangible things in the possession, custody or control of that person, or to permit inspection of premises, at a time and place therein specified
- Specify that fees and mileage need not be tendered to the deponent upon service of a subpoena issued on behalf of the U.S. or agency thereof or on behalf of certain indigent parties and criminal defendants who are unable to pay such costs.

Requirements for Content and Service of a Subpoena

Proper Service of the Subpoena

Oklahoma District Courts. Proper service of a subpoena issued by an Oklahoma district court is determined pursuant to 12 Okla. Stat. §2004.1, which provides that service can be made:

- By personal delivery of the subpoena by any person age 18 and older. The person serving the subpoena is required to make proof of such service to the court promptly, and in any event, before the witness is required to testify.

- By certified mail, return receipt requested, with delivery restricted to the person named in the subpoena. If service is by mail, the person serving the subpoena is required to show in his/her proof of service the date and place of the mailing and attach a copy of the return receipt showing that the mailing was accepted. Acceptance by any University employee with apparent authority would probably constitute valid service by mail.

Federal Courts. Proper service of a subpoena issued by the United States District Court for the Western District of Oklahoma is determined pursuant to Rule 5 of the Federal Rules of Civil Procedure, and requires:

- Personal delivery of the subpoena by a person of suitable age and discretion; or

- By regular mail.

Action Regarding Invalid Subpoenas for Documents. If the subpoena clearly is not valid on its face or was not properly served, legal counsel should notify the attorney issuing the subpoena in writing of the defect, and the fact that it will not be honored. This must be done prior to the earlier of (i) the response time set forth in the subpoena; or (ii) within 14 days of receipt of the subpoena.

Action Regarding Valid Subpoenas. If the subpoena is valid and was properly served, the following procedures should be followed:

- The University, through the applicable Health Care Component, should seek the patient's written authorization form, to release the requested information. The University also should seek approval by the patient's attorney, noted on the authorization form, for release of the subpoenaed information.

- If a patient authorization is obtained, but the attorney approval is not obtained, the University should notify the attorney that the information will be released at a certain date, unless a Motion to Quash the subpoena is filed by the attorney on or before such date.

- If patient authorization to the release of the information is not obtained, the University should request a certified copy of the pleadings in the action to determine whether the patient has waived the physician-patient privilege, requiring disclosure of the information by the University pursuant to the subpoena. Legal counsel to the University should be consulted in determining whether the privilege has been waived.

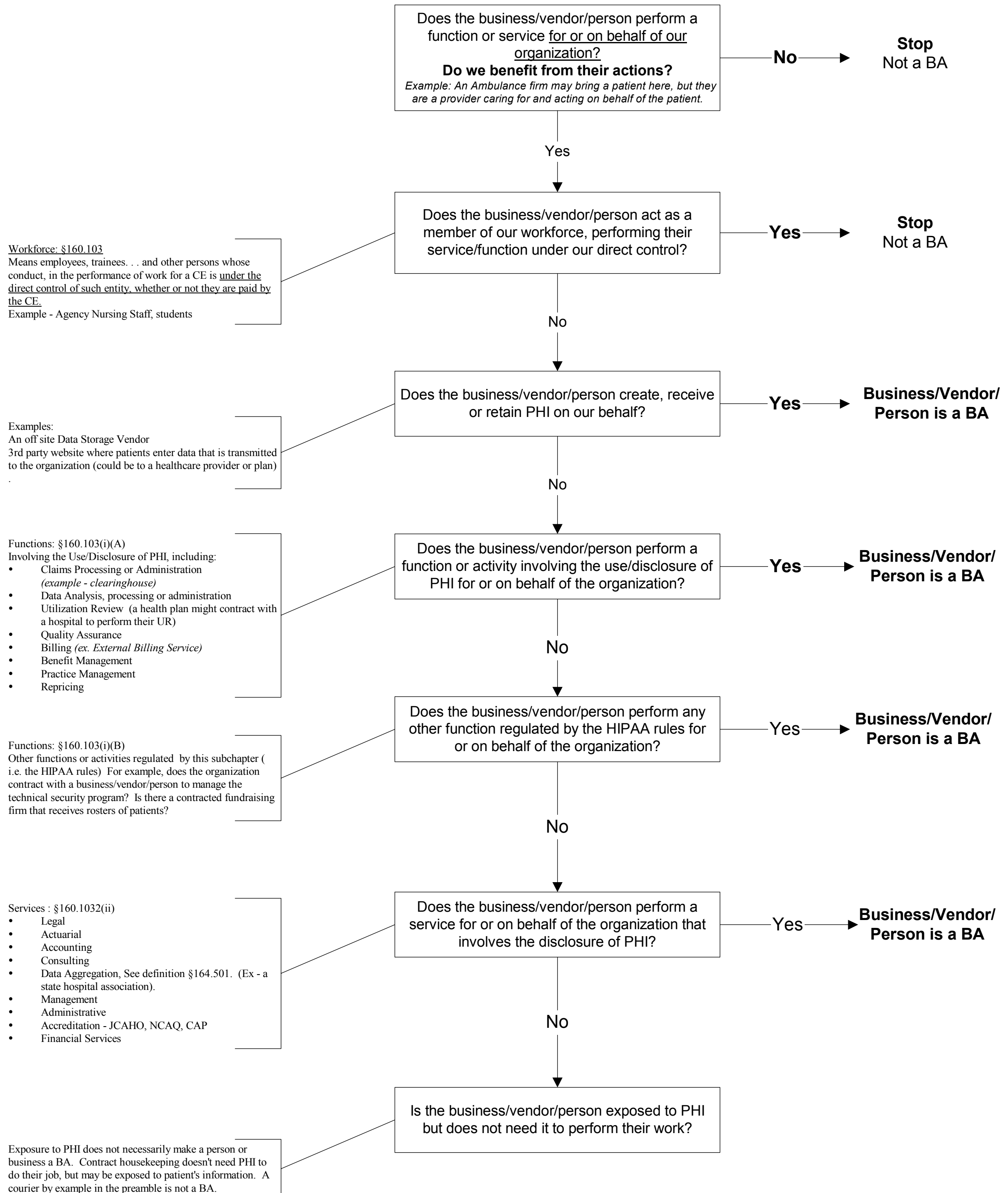
- If legal counsel concurs that the physician-patient privilege has been waived, the University must contact the party responsible for the issuance of the subpoena to obtain the following:

Satisfactory assurance that reasonable efforts have been made to contact the patient whose PHI is being requested.

The University of Oklahoma
HEALTH SCIENCES CENTER

BUSINESS ASSOCIATE (BA) DECISION CHART - correction 4/10/02

Name - Business/Vendor/Person: ____



Research on Decedent's Information Request Form

Principal Investigator:______________________________ **Date**:______________________
Address:____ **Phone #**: (___)_____________

I request access to the medical records of the following deceased individuals for research purposes:

I certify that:

(1) The disclosure sought is solely for research on the protected health information of decedents (and not family members or other third parties);

(2) The protected health information for which use or disclosure is sought is necessary for research purposes.

(3) The people whose information is sought are deceased and I will provide documentation of the death of the individuals if requested to do so.

The following individuals are authorized to review health information on my behalf:

____
Principal Investigator Signature

Approved by:____ ________________________
Facility HIM Director or Business Administrator Date

Reviews Preparatory to Research Request Form

Principal Investigator:______________________________ **Date**:______________________
Address:____ **Phone #**: (___)_____________

I request review of _________________________________ medical records related to _______________________________________ to prepare for a potential research study regarding____.

I certify that:

(1) Review of the protected health information requested will be conducted solely to prepare a research protocol or for similar purposes preparatory to research;

(2) I will not copy nor remove any protected health information from the facility and/or University Health Care component releasing the information in the course of review; and

(3) The protected health information for which use or access is sought is necessary for research purposes.

The following individuals are authorized to review health information on my behalf:

____
Principal Investigator Signature

Approved by:____ ________________________
Facility HIM Director or Business Administrator Date

The University of Oklahoma
HEALTH SCIENCES CENTER

Training and Education Request Form

Requester:_______________________________________ **Date**:_____________________
Address:____ **Phone #**: (___)_____________

I request access to the medical records of the following individuals for educational and/or training purposes: (Request may not exceed 4 records.)

If the entire medical record is not necessary, indicate the type and/or dates of information needed. Dates: From___________________ to ______________________
Type:____

Describe the educational/training purpose or activity for which this request is being made:____
____.

I certify that:

(1) The disclosure sought is solely for an educational/training purpose and will not be used and/or disclosed for any other purpose.
(2) I will only use/disclose the minimum amount of protected health information necessary to achieve the educational/training purpose (e.g., names, contact information and other unnecessary identifiers will be deleted or omitted).
(3) I will safeguard the information while in my possession.
(4) I will destroy the protected health information after it is no longer needed for the educational/training purpose for which it is being sought.
(5) The medical record will not be removed from the facility releasing the information.

______________________________________ ______________________________
Requester's Signature **Title**

Approved by:____ ________________________
Facility HIM Director or Business Administrator Date

DIRECTORY OPT-OUT FORM

I hereby request that my name, general condition, religious affiliation, and location **not be included** in the Facility Directory.

I understand that because my name will not be included in the directory, the facility will tell everyone that inquires about me over the telephone or in person that it has no information about me.

No deliveries will be forwarded to me including cards or flowers.

Print Name:____ **Date:**________________________

Signature:____**Time:**__________________________

OTHER FORMS:	Form #	Document Name/Description
Clinic Fax Form	101	Fax Cover Sheet (no PHI)
Medical Records	102	Phone Inquiry Request for Release of PHI
Medical Records	103	Status of Request for PHI (more information needed to process request)
Medical Records	104	COPY LOG of RELEASED PHI
Medical Records	105	SUMMARY LOG of RECEIVED PHI

The University of Oklahoma
HEALTH SCIENCES CENTER

FAX
Cover Sheet

DATE: ______________________________ **TIME:** ______________________________

WE ARE TRANSMITTING ______ PAGES (including the cover sheet)

IF YOU DO NOT RECEIVE ALL OF THE PAGES, PLEASE CALL US IMMEDIATELY.

PLEASE DELIVER TO:

Name: ____

Facility: ______________________________ **Dept**: ______________________________

Phone #: (____)______________________________ **Fax #** : (____)______________________________

Comments: ____

____

FROM:

Name: ____

Facility: ______________________________ **Dept**: ______________________________

Phone # : (____)______________________________ **Fax #** : (____)______________________________

*** * NOTICE * ***

The information contained in the transmission accompanying this notice is confidential and protected by the physician-patient privilege. It is intended only for the use of the individual or entity identified above. If the reader of this message is not the intended recipient, you are hereby notified that any dissemination or distribution of the accompanying communication is prohibited. The parties sending the accompanying documents do not waive the physician-patient privilege. If you have received this communication in error, please notify us immediately by telephone (collect), and return the original message to us at the above address via the United States Postal Service. We will reimburse you for your postage. Thank you.

Form 101
Rev. 11/02

Medical Records Department
Phone Inquiry
Request for Protected Health Information

Date: ____________________ **Medical Record #** :__________________

SUBJECTS TO COVER WITH PATIENT:

1. What is the patient's full name? ____

2. Who is the person calling if different from the patient?

   ____
   Name Relationship to patient

3. Return phone # : (____) ___________________________

4. What is the patient's DOB :_________________________

5. What is the patient's Social Security #: ________________________________

6. Who is the patient's Doctor (s) :

   ____

   ____

7. Has the patient signed a Release of Information?
   [ ] YES
   [ ] NO If no, ask if the patient/person calling has access to a fax machine **or** do they want a release mailed to them?

   Fax # : (____) ________________________________

   Address: ____

8. **VERIFY INFORMATION IS CORRECT BY REPEATING PHONE / FAX NUMBERS AND ADDRESS.**

9. **Be sure to let patients and/or companies know there is a $ .25 charge <u>per</u> copied page, $5.00 <u>per</u> x-ray film copied, plus postage.**

Person documenting phone inquiry : ____

Form 102
Rev. 11/02

The University of Oklahoma
HEALTH SCIENCES CENTER

Status of Request for Protected Health Information

Date: ______________________________ **Medical Record #:** ________________________

Patient Name: ____

[ ] We have received your request for medical information on the above patient.

[ ] We have received attached documentation and are unable to identify this patient in our system.

Please see response checked below:

1. ______ Additional information required to locate medical record:

   [ ] Date of birth
   [ ] Social security number of patient
   [ ] Another name patient used
   [ ] Referring physician
   [ ] Spelling clarification
   [ ] Name of patient's physician
   [ ] Date and/or types of services rendered to patient

2. ______ Additional information required to locate medical record:

   [ ] No legal authorization
   [ ] Not signed by patient or legal representative
   [ ] Name and address from which information is to be obtained
   [ ] Name and address to which information is to be released

3. ______ Authorization not legal:

   63 Okla. Stat § 1-502.2B requires that the following specific language be included on every release:

   The information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea and the Human Immunodeficiency virus, also know as Acquired Immune Deficiency Syndrome (AIDS).

   Please complete and return the attached legal authorization.

4. ______ No medical record found on patient, and/or date(s) of service.

5. ______ Additional documentation required for deceased patients:

   [ ] Court-certified copy of guardian or personal representative appointment
   [ ] Original Power of Attorney (We will make a copy and return original to you)
   [ ] Copy of Death Certificate

6. ______ **Records copied and mailed on** ______________________________