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| --- | --- | --- |
| ou-logo | **The University of Oklahoma**Enter Entity Here | Insert College /Department NameInsert College/Department Street AddressInsert College/Department City State and ZIP |
|  |  |  |
| **Consent for Electronic Communication of Medical Records** |
|  |
| Last Name: |  | First: |  | Middle: |  |
| Other Names Used: |  | Birthdate: |  |
| Address: |       | City: |       | State: |       | Zip: |       |
| Home Phone: | ( )       |  Alt. Phone: | ( )       |  Cell Phone: | ( )       |
|  |

[ ]  I have submitted a Request for Health Information/Records and I authorize OU to send my records to me via email at the email address below:

[ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

- or -

[ ]  I have submitted an authorization to Release Health Information/Records and I authorize OU to send my records to a third party via email at the email address below:

[ ]  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_@\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

**I understand the security of email and text messages cannot be guaranteed and that unauthorized individuals may be able to access the messages.**

I understand the information sent via electronic communication may include information that may indicate the presence of a communicable disease or non-communicable disease, mental health records, or substance use disorder records

It is my responsibility to notify OU if the email address information changes after submitting this form.

I understand that this service of electronic communication is offered solely at the discretion of the OU entity named above and may be withdrawn at any time.

**I understand and agree to the statements above and wish to have my records emailed to the recipient listed above.**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| **Signature of Patient, Parent, or Authorized Legal Representative\*** |  | **Relationship to Patient** |  | **Date** |

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