OKLAHOMA DEPARTMENT of CORRECTIONS

ACKNOWLEDGEMENT of REQUEST for PROTECTED HEALTH INFORMATION

To: _____ Date: _____

Address: _____ City: _____ State: _____ Zip: _____

Regarding: _____ ODOC #: _____

Your request for protected health information regarding the above individual was received on _____
(Date)

SECTION I.

The protected health information is complete and ready to forward to the address above. In accordance with Oklahoma State Statue Title 76, Section 19, copies will be provided at $.50 per page plus the cost of postage. Payment will be received prior to disclosing the information.

Copied _____ pages @ $ .50 per page equals $_____ plus the cost of postage _____equals $_____ total due/paid.

Please send your remittance to:

Facility: _____ Attention: _____

Address: _____ City: _____ State: _____Zip_____

_____
Signature/Title Date

SECTION II.

☐ We are required by law to inform you the information you requested can not be gathered within 30 days; therefore, the information will be provided to you by _____.

☐ Your request for protected health information could not be processed due to the following:

- ☐ Medical records are destroyed five years after the individual is discharged.
- ☐ The individual you have requested information on cannot be located in our records. Please provide additional information.
- ☐ There is reasonable doubt as to the validity of the authorization.
- ☐ The authorization is invalid and lacking the information checked below:
  - ☐ Expiration date
  - ☐ Dates of protected health information to be disclosed
  - ☐ To whom and where the protected health information is to be disclosed
  - ☐ Purpose of the disclosure
  - ☐ The extent or nature of protected health information to be disclosed
  - ☐ Signed and dated authorization by the individual
  - ☐ The personal representative did not provide a description of the authority to act on behalf of the individual
  - ☐ Required statement the individual has the right to revoke the authorization in writing
  - ☐ Required statement: **THIS INFORMATION AUTHORIZED FOR RELEASE MAY INCLUDE RECORDS WHICH MAY INDICATE THE PRESENCE OF COMMUNICABLE OR VENEREAL DISEASES, WHICH MAY INCLUDE, BUT ARE NOT LIMITED TO DISEASES SUCH AS HEPATITIS, HERPES, SYPHILIS, GONORRHEA, AND HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOWN AS ACQUIRED IMMUNODEFICIENCY SYNDROME (AIDS).**

_____
Signature/Title Date

SECTION III. OKLAHOMA DEPARTMENT of CORRECTIONS' USE ONLY

Payment Received: _____ _____
(Date) Signature/Title

Copies of protected health information sent: _____ _____
(Date) Signature/Title

Original: Chart DOC 140108I (R 11/22)
Copy: Individual requesting protected health information