## Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I understand that as part of my health and medical care, Medical Specialists, Inc. originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for the future care and treatment. I further understand that this information serves as:

- a basis for planning my medical care and treatment
- a means of communication among health professionals who contribute to my care
- a source of information for applying my diagnosis and treatment information to my bill
- a means for a third-party payer to verify that services were billed as actually provided
- and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

**I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.**

I understand and have been provided with a **PATIENT PRIVACY NOTICE** that provides a more complete description of the information uses and disclosures. I understand that I have the right to review the **PATIENT PRIVACY NOTICE** prior to signing this consent. I understand Medical Specialists, Inc. reserves the right to change their notice and practices, but that prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Medical Specialists, Inc. is not required to agree to the restriction requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Oklahoma law we are required to notify you .... **that the information authorized for release may include records which may indicate the presence of a communicable or venereal disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea and human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

In addition to the releases outlined above, information may be released to the following individuals/organizations for indicated purposes:

_____ _____

_____ _____

I request the following restrictions to the use and/or disclosure of my health information: _____

You may leave appointment reminders, medical information on my message service or machine. YES NO
You may fax information to me. YES NO My fax number is: _____

_____ _____
Signature of Patient or Legal Representative Date Notice Effective

Medical Specialists Inc. ____ accepts ____ denies ____ accepts conditionally the restrictions imposes on release of information as stated above.

_____ _____
Signature/ Title Date