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

I understand that as a part of my child(ren)'s health and medical care, South Tulsa Pediatrics originates and maintains medical and health records describing my child(ren)'s health history, symptoms, examination and test results, diagnoses, treatment, and plans for future treatment or care. I further understand that this information serves as:

- A basis for planning care and treatment of my child(ren)
- A means of communication among the health professionals who contribute to my child(ren)'s care
- A source of information for applying the diagnosis and treatment information to the bill
- A means for third-party payers 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 information uses and disclosures. I understand that I have the right to review the **PATIENT PRIVACY NOTICE** prior to signing this consent. I understand that **South Tulsa Pediatrics** reserves the right to change their notice and practices, but that prior to implementation will mail a copy of revised notice to the address I have provided. I understand that I have the right to object to the use of my child(ren)'s health information for directory purposes. I understand that I have the right to request restrictions as to how my child(ren)'s health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that South Tulsa Pediatrics is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent that South Tulsa Pediatrics has already taken action in reliance thereon.

According to Oklahoma State law you must be advised: **The information authorized for release may include records which indicate the presence of a communicable or non-communicable disease. I further understand that medical information may indicate that the patient has or has been treated for psychological or psychiatric conditions or substance abuse.**

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

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I request the following restrictions to the use and/or disclosure of my child(ren)'s health information:

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Please refer to our financial policy for a detailed explanation of your rights and responsibilities of payment. If we are contracted with your insurance plan, we will file insurance claims according to our agreement with the participating insurance plan if you provide us completed financial information forms and a copy of the insurance card for each covered member of the family.

You ____ may ____ may not leave (appointment reminders) (medical information) on my message service or machine.

You ____ may ____ may not fax information to me. My fax number is: _____________________

You ____ may ____ may not contact me by e-mail. My email address is:

_________________________@_________________________

____ ________________________ ______________

Signature of Patient or Legal Representative Relationship to patient Date