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

I understand that as part of my health and medical care, Avalon Park Pediatrics originates and maintains medical and health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means for 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 in writing.

I understand and have provided with a **PATIENT PRIVACY NOTICE** that provides a more complete description of information uses and disclosures. I understand the right to review the **PATIENT PRIVACY NOTICE** prior to signing this consent. I understand that Avalon Park Pediatrics reserves the right to change their notice and practices, but that prior to implementation will mail a copy of the revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information my be used or disclosed to carry out treatment, payment or healthcare operations and that (Avalon Park Pediatrics) is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to 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 communicable or venereal disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea and the 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 the indicated purposes:

_____ _____

_____ _____

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

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 email.

My email address is: _____@_____.

Payment Policy: I understand that if Avalon Park Pediatrics is not contracted with my insurance carrier, I must pay in full at the time of service. I understand that my insurance carrier may pay less than actual bill for services. I also understand that some services provided by Avalon Park Pediatrics may not be covered by my benefit plan. I agree to be responsible for payment of all services rendered. **I understand that all co-payments or deductible amounts are due at the time of service.** I understand that any balance generated is due within 10 days of the billing date. I realize failure to keep this account current may result in Avalon Park Pediatrics being unable to provide additional services.

_____ _____
Signature of Patient or Legal Representative Date Notice Effective

_____
Patient Name (Printed)

Avalon Park Pediatrics _____accepts _____denies_____accepts conditionally the restrictions imposed on release of information as state above.

_____ _____
Signature/Title Date