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

(Revised: 13Jun2013)

I understand that as part of my health and medical care, Options Health Research, LLC originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care. 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 a third-party payer to verify that services were billed as actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand that this agreement to release information shall apply to all information accumulated up to this date and 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 Options Health Research, LLC reserves the right to change their notice and practices, and 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 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 Options Health Research, LLC is not required to agree to the restrictions request. I understand that I must revoke this consent in writing. Revocation of this consent may not be applied retroactively.

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 are 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 purpose:

Spouse: _____
Parents _____
Children: _____
Other: _____

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

_____

***Circle Yes or No below – **At least one daytime contact number must be provided.**

Yes/No You may leave appointment reminders, medical information, and insurance/payment arrangements at my home.
_____**Cell phone (call or text);**_____**Home phone**; _____**e-mail**
Yes/No You may call me at work._____ Work phone
Yes/No You may fax information to me. My fax number is: _____

_____ _____
Patient Date Notice Effective

_____ _____
Health Care Proxy Relationship