Central Oklahoma Clinical Associates
First Choice Urgent Care

HIPAA Consent Form

This consent form must be completed and signed prior to receiving medical treatment from our office. Please return this form to the reception upon completion.

I understand that as part of my medical care, this office originates and maintains medical records describing my health history, symptoms, examination 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 for 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
- and as a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professional

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 are not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also know as Acquired Immune Deficiency Syndrome (AIDS).**

Other than myself, my spouse, or others previously identified in the Privacy Notice, this office has permission to use and disclose information regarding my medical care to the following specific person(s):

_____

This agreement to release future information shall remain in force until such time as I 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 notice prior to signing this consent. I understand that this office reserves the right to change the notice and practices, but that prior to implementation, a copy of any revised notice will be provided. 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 my doctor is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action.

_____
Patient's Full Name

_____ _____
Signature of Patient or Legal Representative if minor Printed Name and Relationship to Patient

_____
Today's Date (Effective date of notice)

****Note:** If you wish to have a copy of this consent form please notify the receptionist.