

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

I understand as a part of my health and medical care, AMC Urgent Care Plus originates and maintains medical and health records describing my health history, symptoms, examination and test results diagnoses, treatment, and any plans for future care or treatment. I further understand this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who contributes 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 services were billed as actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

**I further understand and agree 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 the patient has been provided with a PATIENT PRIVACY NOTICE which provides a more complete description of information uses and disclosures. I understand I have the right to review the PATIENT PRIVACY NOTICE prior to signing this consent. I understand this office reserves the right to change their signing this consent. I understand this office reserves the right to change their notice and practices. I understand I have the right to object to the use of my health information for directory purposes. I understand I have the right to request restrictions as to how my health information may be used or disclosed to carry our treatment, payment or healthcare operations and this office is not required to agree to the restrictions requested. I understand I must revoke this consent in writing, except to the extent the organizations has already taken action in reliance thereon.

By Oklahoma law we are required to notify you...the information authorized 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 known as Acquired Immune Deficiency Syndrome (AIDS).

Information may be released to the following individuals/organizations for the indicated purpose:

NAME:

RELATIONSHIP:

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

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You \_\_\_\_\_ may \_\_\_\_\_ may not leave (appointment, medical information etc.) on my message service or machine.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Date Notice Effective

AMC Urgent Care \_\_\_\_\_ accepts \_\_\_\_\_ denies or \_\_\_\_\_ accepts conditionally... the restrictions imposed on release of information as stated above.

\_\_\_\_\_  
Signature/Title

\_\_\_\_\_  
Date