Broken Arrow Family Clinic
705 West Oakland Street
Broken Arrow, OK 74012
Phone: 918-251-2666 Fax: 918-258-7790

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

I understand that as part of my health and medical care, Broken Arrow Family Clinic originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I further understand that this information serves as:

- A basis for planning my cure 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 to verify that services 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 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 Broken Arrow Family Clinic reserves the right to change their notice and practices, but 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 may be used or disclosed to carry out treatment, payment, or healthcare operations and that Broken Arrow Family Clinic 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 in reliance thereon.

By Oklahoma law, we are required to notify you that the information authorized for release may indicate the presence of a communicable or venereal disease which may include, but not limited to, diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus (HIV) and the acquired immune deficiency syndrome (AIDS).

In addition to release outlined above, y information may be released to the following individuals/organizations:

_____

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

_____

You may___or may not___leave appointment or other medical information on my voicemail or answering machine, fax or email.

Signature_____ Date_____

End of Life Planning:

When you visit Broken Arrow Family Clinic you have the right under Oklahoma State Law to make decisions about the care you receive. You have the right to accept or refuse any treatment or procedure tht your provider recommends for you. Your provider will prescribe a treatment plan for you and discuss their recommendation with you. You should ask for additional information concerning that you do not understand completely. Broken Arrow Family Clinic recommends that you tell us who should make decisions regarding your care if you become unable to make those decisions yourself.

Usually, this is your spouse or a family member who knows your wishes, but it can be another individual who knows you best.

1. Do you have a "Living Will" or Advanced Directive for Healthcare? Yes☐ No☐
2. Do you have a "Power of Attorney"? Yes☐ No☐

   If "Yes", please list their name_____Relationship to you_____
3. Have you designated a person that you want to make health care decisions on your behalf if you become physically or mentally unable to do so? Yes☐ No☐

   If "Yes", please list their name_____Relationship to you_____

I understand that I am not required to have an Advance Directive for healthcare in order to receive treatment. I also understand that if I do not appoint a healthcare proxy, my family's right may be limited under Oklahoma law. I have been given the explanation of my right to accept or refuse treatment and formulate an Advance Directive.

Patient Signature _____ Date_____

(Parent or Guardian signature above is patient is under 18)

Printed name _____ Date of Birth_____
(Patient's Name)

Broken Arrow Family Clinic

___ accepts ___ denies ___accepts conditionally the restrictions imposed on release of information