Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Infectious Diseases Consultants of Oklahoma City may use and disclose **protected health information** about me to carry out **treatment, payment and healthcare operations.** Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Infectious Diseases Consultants of Oklahoma City reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Privacy Officer at:

Infectious Diseases Consultants of Oklahoma City

Name of Privacy Officer | Practice

Address | City, State, Zip

Telephone

With my consent, Infectious Diseases Consultants of Oklahoma City may call my home or another designated location and leave a message (on voice mail, answering machine or in person) in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory and other results.

Mail

With my consent, Infectious Diseases Consultants of Oklahoma City may mail to my home or another designated location any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder cards, correspondence and billing statements.

Email

With my consent, Infectious Diseases Consultants of Oklahoma City may e-mail to my home or another designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards, correspondence and billing statements.

I have the right to request that Infectious Diseases Consultants of Oklahoma City the use or disclosure of my protected health information to carry out treatment, payment and healthcare operations. (Please request form.)

I understand that the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I consent to the use and disclosure of my protected health information to carry out treatment, payment and healthcare operations by Infectious Diseases Consultants of Oklahoma City.

I may revoke my consent in writing except to the extent that the practice has already made disclosures based upon my prior consent. If I do not sign this consent, Infectious Diseases Consultants of Oklahoma City may decline to provide treatment to me.

Print Patient's Name | Signature of Patient **or Legal Guardian* | Date

Attention Privacy Officer:

Offa patient wishes to limit how he or she is contacted by our practice or the refease of information, please refer the patient to the form titled Request for Limitations and Restrictions of PHI.