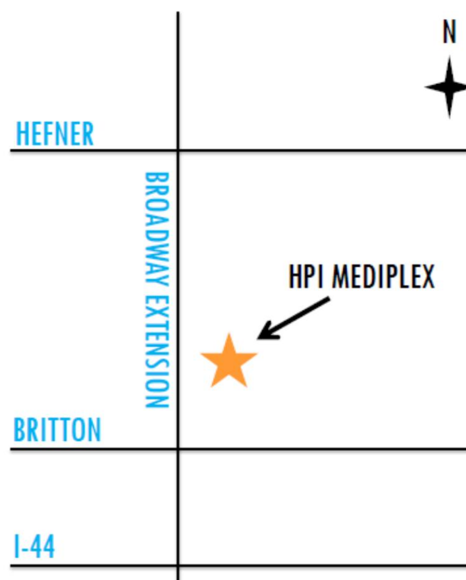
WELCOME TO OUR OFFICE

Enclosed is your new patient paperwork for your upcoming appointment.

- Please check in 15 minutes prior to your appointment and bring this paperwork completed along with your insurance and photo ID.
- Please gather any imaging you have of your neck and/or back (MRI, CT, X-rays). We will need a digital copy of these images for diagnostic purposes.
- Although we accept all major insurance policies, we do recommend that you check with your insurance company to make sure the provider you're scheduled with is contracted with your specific plan.
- Please note that our office is not specialized to treat chronic pain and therefore should not be relied upon to prescribe narcotic medication. We reserve the right to prescribe narcotic medications for patients who have been treated in our clinic surgically.
- Our address is 9800 Broadway Extension, Suite 203, Oklahoma City, OK 73114. Please contact our office at (405) 424-5415 if you have any questions.
- We are located inside of the HPI Mediplex.
- For more information about our office, please visit our website at www.thespineclinicok.com
- Thank you and welcome to The Spine Clinic of Oklahoma City!



BAB

9800 Broadway Ext. • Oklahoma City, OK 73114 • Phone 405.424.5415

PATIENT INFORMATION
(Please print – Fill in ALL blanks)

Patient's Legal Name: Last	First	M.I.	Sex: **M F**	DOB:	Age:

Social Security Number:	Marital Status: ___Single ___Married ___Widowed ___Divorced ___Separated
Patient's Address:	Employment Status: __Employed __Full-time Student ___Part-time Student ___ Retired

City:	State:	Zip Code:	Email:
Home Phone:	Work Phone:		Cell Phone:
Ethnicity: ___Hispanic ___Non-Hispanic___Declined	Race: _____White _____Asian _____Black _____Pacific _____Native American _____Multiple _____Other		Preferred Language:

INSURANCE INFORMATION – We will need a copy of your insurance card in order to file a claim

Name of Primary Insurance Company:	
Policyholder Name:	Relationship to Patient:
Policyholder DOB:	Policyholder SSN:
Policyholder Employer:	
Secondary Insurance (if applicable):	
Policyholder Name:	Relationship to Patient:
Policyholder DOB:	Policyholder SSN:
Policyholder Employer:	

EMPLOYMENT INFORMATION

Patient's Employer:	Phone Number:
Insured Employer:	Phone Number:

If the patient is a minor, please list both parent names and employers

Mother	Employer:	Phone Number:
Father	Employer:	Phone Number:

NEXT-OF-KIN INFORMATION

Nearest relative (or friend, not spouse), not living with you:	
Home Phone:	Relationship to patient:

WHO REFERRED YOU TO OUR OFFICE (circle one)

Adjustor	Attorney	Billboard	Case Manager	Doctor	Employer	Friend	Hospital	Insurance
Magazine	Neighbor	Phone Book	Physical Therapist	Coach	Radio	School	Trainer	Other

THIRD PARTY BILLING (circle one)

Is your injury work related	YES	NO
Is this injury due to an accident	YES	NO
If your injury is MVA related have you obtained an accident report?	YES	NO

I hereby authorize my insurance to be paid directly to the facility and the physician. I acknowledge that I am financially responsible for non-covered services. I also authorize the physician to release my information in the processing of any insurance claims. I acknowledge & agree that I have received a copy of the TPG Privacy Notice.

Signature:	Date:

BAB

OKLAHOMA SPORTS SCIENCE & ORTHOPAEDICS

Authorization to Release Information via Phone/Family/Friends

Patient Name:____ DOB:_________________________

I hereby authorize confidential communications from the physicians or staff of OSSO regarding my health, care, treatments, appointments, prescriptions, etc…to be received at any of the numbers given below. I authorize the staff to leave messages on the voicemail or with the individual who answers the phone at any of the below numbers:

Home Phone: _________________________________ Work Phone:__________________________________

Cell Phone: ___________________________________ Other: _______________________________________

I authorize the following individuals to call the office on my behalf to verify the status of appointments, treatment plans, medications and account information. These individuals may also pick up prescriptions and/or samples that I have requested:

Name: _______________________________________ Relation: _____________________________________
Name: _______________________________________ Relation: _____________________________________
Name: _______________________________________ Relation: _____________________________________
Name: _______________________________________ Relation: _____________________________________

I understand that this authorization will remain in effect until I revoke the authorization in writing.

____ ______________________________

Patient Signature Date

DISCLOSURE OF PHYSCIAN OWNERSHIP
NOTICE TO PATIENTS

Please carefully review the information contained in this notice.

As a prospective patient of Community Hospital or Northwest Surgical Hospital, we are pleased to inform you of the following:

1. Dr. Brett Braly has an ownership interest in Community Hospital and Northwest Surgical Hospital.

2. In addition, other physicians that may treat you at the hospital may have an ownership interest in the hospital.

3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a healthcare facility other than Community Hospital or Northwest Surgical Hospital. You will not be treated differently by your physician if you choose to use a different facility. If desired, your physician can provide information about alternative providers.

We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask your physician or any representative of Community Hospital or Northwest Surgical Hospital. For a full list of our physician owners and additional information about our healthcare facilities, please visit our website at communityhospitalokc.com or nwsurgicalokc.com.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and hereby understand that your physician has an ownership interest in Community Hospital and Northwest Surgical Hospital.

______________________________________ ______________________________________

Signature of Patient

Signature of Parent of Guardian
(if applicable)

______________________________________ ______________________________________

Print Name of Patient

Print Name of Parent of Guardian

Dated:______________________________________

BAB

OKLAHOMA SPORTS SCIENCE AND ORTHOPAEDICS

FINANCIAL POLICY

Thank you for choosing Oklahoma Sports Science & Orthopaedics (OSSO) your premier healthcare provider. At OSSO, we are dedicated to providing the highest quality, most cost effective care. We specialize in adult and pediatric orthopedics, sports medicine, running injuries, physical medicine and rehabilitation, pain management, reconstructive and orthopedic spine surgery, and hand surgery.

In addition to accepting traditional insurance plans and Medicare, we are contracted with numbers Preferred Provider Organizations (PPO) and Health Maintenance Organizations (HMO). Because each plan is different, and constantly updating providers' participation status, please check with your particular plan to make sure we are currently participating in your network. We ask that you assist us in maximizing your insurance coverage by cooperating fully in all referral, prior authorization and pre-certification processes. Please be aware that all insurance carriers do not consider some services rendered a covered benefit. It is important that you are aware of your insurance policy provisions of coverage.

Accurate, up-to-date information is the patient's responsibility; please notify our office of any changes in your insurance or personal billing information. Please bring you current insurance card(s), or any other information that is required by your insurance company to each appointment. By maintaining updated information this ensures that your medical claims are filed correctly and prevents any unnecessary delays in processing your claim.

Payment for all co-insurance, deductible and non-covered services are due at the time of service unless special payment arrangements have been made. Payments can be made by cash, check, money order, Visa, Discover, American Express, or MasterCard. We do have a payment plan for patients who have financial concerns. Please notify our office at 419-8444 to make financial arrangements. Please be aware that charge for physical therapy, durable medical equipment, laboratory testing, anesthesia, hospital, ambulatory surgery facilities and some radiology services may be billed separately.

If your injury was due to a motor vehicle accident (MVA) you will be setup on a self-pay account for any charges incurred up to $500. If charges exceed $500, a claim will be filed with the third party insurance carrier. In order to file this claim, complete billing information will be requested from the patient. A lien may be filed with the third party in order to ensure payment to the physician. Please note that not all OSSO Physicians will accept third party/MVA patients.

There is a $35 charge for any FMLA, disability, or accidental form completed. This charge is applicable per form completed and is payable prior to completion.

If you require surgery or other invasive procedures and are scheduled at Community Hospital or Northwest Surgical Hospital, please be advised that your physician may have ownership in those facilities. If you wish, you may request another facility.

Again, thank you for allowing Oklahoma Sports Science & Orthopaedics to participate in your care.

Sincerely,

OSSO Physicians and Staff

My signature below acknowledges receipt of this financial policy:

Signed____ Date____________________

(signature of person financially responsible for payment)

Relationship if other than patient____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided with the Notice of Privacy Practices (“Notice”):

- The Notice tells me how The Physicians’ Group, LLC or HPI Physicians, LLC, as applicable (the “Practice”), will use protected health information for the purposes of treatment, payment for treatment, and health care operations.

- The Notice explains in more detail how the Practice may use and share protected health information for other than treatment, payment, and health care operations.

- The Practice will also use and share protected health information as permitted or required by law.

- If I am a patient receiving health services at the Practice, I consent to the Practice using and disclosing my protected health information contained in my treatment records maintained by the Practice for the purposes detailed in the Practice’s Notice of Privacy Practices.

Patient’s Name (print): ____

Patient’s Date of Birth: ____

This form must be signed by either the patient of by the patient’s personal representative.

If this form is signed by the patient’s personal representative, please provide a copy of the document naming the personal representative and provide a description of the personal representative’s authority to act on behalf of the patient: ____

____

____ Date: _________________

Signature of Patient or Patient’s Personal Representative

Current Contact Information for Patient of Personal Representative signing this form:

Name (print): ____

Address: ____

Telephone Number: ____

Email: ____

AUTHORIZATION FOR TREATMENT

I hereby authorize the physician(s) in charge of the care of the patient of Oklahoma Sports Science & Orthopaedics to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize the physician(s) of Oklahoma Sports Science & Orthopaedics to disclose any or all of the information in my medical records to any person, corporation or agency which is or may be liable for all or part of Oklahoma Sports Science & Orthopaedics charge or who may be responsible for determining the necessity, appropriateness, amount or other matter to the physician's treatment or charge including, but not limited to, insurance companies, health maintenance organizations, preferred provider intermediaries or carriers. I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THAT I HAVE A COMMUNICABLE DISEASE WHICH MAY INCLUDE BUT IS NOT LIMITED TO DISEASE SUCH AS HEPATITIS, SYPHILIS, GONORRHEA OR THE HUMAN IMMUNODEFICIENCY VIRUS, ALSO KNOW AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS). With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning identity, and release Oklahoma Sports Science & Orthopaedics, its agents and its employees from liability in connection with the release of the information contained within.

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to my physician(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit at Oklahoma Sports Science & Orthopaedics. I understand I am financially responsible for charges not covered by this assignment.

You agree that, to the fullest extent permitted by law, we may remit all or a portion of any credit balances or other amounts due to you from us to any of our affiliates to whom you have any balance owing fees, items or services. We will advise you of any payments we make on your behalf to our affiliates.

WAIVER OF RESPONSIBILITY OF VALUABLES

I hereby release Oklahoma Sports Science & Orthopaedics from any claim for responsibility or damages in the event of loss of my property, including money and jewelry.

I understand that a photocopy of this document is as valid as the original.

SIGNED____ DATE ________________________

(patient)

OR ____

(nearest relative or responsible party)

____ Policyholder's Signature________________________

(relationship to patient)

NOTICE TO PATIENTS: Information in your medical record that you have/may have a communicable or venereal disease is made confidential by law and cannot be released without your permission, except in limited circumstances, including release of persons who have had risk exposures, release pursuant to an order of the court of the Dept. of Health, release among healthcare providers or release for statistical or epidemiological purposes. When such information is released, it cannot contain information from which you could be identified unless release of that identifying information is authorized by you, by an order of the court, or the Dept. of Health, or by law.

BAB

Appointment No Show and Late Policy for The Spine Clinic of Oklahoma City

Appointment No Shows

A NO SHOW appointment is a missed appointment without notifying our office 24 hours prior to scheduled appointment. If your appointment is scheduled for a Monday, we require notification no later than the Friday prior to your appointment.

- The first no show will result in a call or email reminding you that you have missed your appointment and will need to reschedule for another day.
- The second no show will result in a call or email and a $50.00 charge to the patient, not your insurance company. This must be paid prior to scheduling your next appointment.
- The third no show will result in a dismissal from the practice.

Late Policy

We understand that even the most punctual person can occasionally run late. If that is the case, please call us prior to your appointment time so we can get you rescheduled. If the schedule allows, the appointment time will simply be shifted to accommodate the delay. However, if the tardiness can't be accommodated, we will reschedule your appointment for another day. If you are late to your appointment, but do not call us prior to your appointment time, we will give your time away to another patient.

- Patients arriving early or on time will be seen in the order they were scheduled.
- Post-operative patients arriving 10-30 minutes late will be seen, but will have to wait while we see patients who arrived to their scheduled appointment on time.
- Non Post-operative patients arriving 10-30 minutes late will be asked to reschedule.
- Any patient arriving more than 30 minutes late will be asked to reschedule.

____

Signature of Patient   Signature of Parent or Guardian (if applicable)

____

Print Name of Patient   Print Name of Parent or Guardian

Dated:______________________________

BRETT A. BRALY, M.D.
POLICY FOR SHORT TERM NARCOTIC PRESCRIPTIONS

Print Patient Name: ____________________________________ DOB: _________________

The purpose of this agreement is to prevent misunderstandings about certain medications the patient may be given. This is to help both the patient and the provider comply with the law regarding post-surgery pain management. Please read this contract thoroughly as it is a condition of your continued treatment. Your signature will be required.

The use of opioids may cause addiction and is only one part of a complete treatment plan.

I agree to the following:

1. I understand that as a surgical patient, I will receive narcotic pain medication for a maximum of ninety (90) days post-surgery. If narcotic medication is still needed after this time, I will be referred to a pain management physician for further care.
2. I am responsible for my medications. I will not share, sell, or trade my medication. I will not take any medication that is not prescribed to me.
3. Forging or altering a narcotic prescription or distributing medications to others is a crime. I understand that should any of the above occur, my entire care with this office will be terminated and I will be reported to law enforcement authorities.
4. Excessive phone calls requesting increased dosages or frequency is viewed as drug-seeking behavior. Changes in medication will not be made without an office visit.
5. I will not increase my medication until I speak with my doctor or nurse.
6. My medication may not be replaced if it is lost, stolen, or consumed sooner than prescribed.
7. I will keep all appointments set up by my doctor. I will notify my doctor's office at least 24 hours prior to my scheduled appointment if I must cancel. Multiple cancellations, no-shows, or rescheduled appointments may be considered non-compliance and may result in my termination as a patient.
8. I will not use any illegal or controlled substances (including marijuana, cocaine, amphetamines, etc.) and if asked, agree to give a blood or urine sample to test for any drug not consistent with my treatment plan.
9. I understand that my doctor's office will utilize the Oklahoma Bureau of Narcotics Drug Tracking Program.
10. I understand that narcotics can adversely affect my judgment in making business decisions and in operating equipment such as an automobile.

Refills

1. I understand that if the medication requires a written prescription, I must call 3 business days in advance. If the medication does not require a written prescription, I will call my pharmacy 3 business days in advance and have them fax the request to the office.
2. I understand that refills will be made only during regular office hours—Monday through Friday, 8:00AM-4:30 PM. No refills will be available on nights, holidays, or weekends. Advance notice of 3 business days is required.
3. I must keep track of my medications. No early or emergency refills may be made.
4. Prescriptions must be filled before expiration. In the event the prescription has expired, the prescription must be returned to this office before a new prescription will be written.
5. I will only use one pharmacy to get my medication. My doctor may talk with the pharmacist about my medications. The name and phone number of my pharmacy is ______________________________.

Emergencies

In the event of a new injury or significant change in your condition, please call our office to make an appointment. In the case of a true medical emergency, please go directly to the ER or call 911. Patients are responsible for notifying any other doctor they see that they obtain narcotics from this office. Patients are responsible for notifying this office of any treatment received by the ER or another physician.

Prescriptions from Other Doctors

If I see another physician who gives me a controlled medication, I must notify my doctor. This includes a dentist, an ER physician, or any other provider. I am not to seek or accept medications from other providers without my doctor's permission, except in the event of a true medical emergency, in which case I must notify my doctor as soon as possible.

Termination of Agreement

If I violate the terms of this agreement, if my drug test results are inconsistent with my treatment plan, or if my doctor decides that a medication is no longer effective, the medication(s) will be stopped by my doctor in a safe way and no refills will be made. If any violation occurs, my doctor may dismiss me as a patient of the practice and ask me to select another doctor. Any violation of this contract will remain a part of my permanent medical record. This contract will remain enforced throughout the entire course of my treatment plan.

I have read and understand this policy.

Patient's signature ____ Date ______________

BAB

Patient name:________________________ DOB:______________Appointment Date: __________________

Patient chart number: _______________________________________

New Patient Questionnaire

What is your preferred pharmacy? (Please include phone number and/or location)

____

Please provide **first & last** names of your primary care physician and any other provider you would like us to contact regarding your healthcare: ____

____

____

Please describe your neck and/or back concerns: ____

____

____

Have you had any previous spine surgeries? If yes, what was the surgery, when was the surgery, and who was the physician? ____

____

____

Have you in the past, or are you currently, receiving any of the following treatments?
Please list the physician and/or types when applicable.

- ☐ Chiropractic ____
- ☐ Injections ____
- ☐ Medication(s)
  - o Prescription ____
  - o Over the Counter ____
- ☐ Physical Therapy ____
- ☐ Home Exercises ____

Other: ____

BAB

Patient name:_________________________ DOB:_______________Appointment Date: ___________________

Medical History Form

Review of Systems

Are you CURRENTLY experiencing any of the following symptoms?

General:
- ☐ Chills
- ☐ Excessive weight gain/loss
- ☐ Fatigue
- ☐ Fever
- ☐ Night Sweats
- ☐ Weakness

Skin:
- ☐ Discoloration
- ☐ Easy bruising
- ☐ Hives
- ☐ Jaundice
- ☐ Rash

HEENT:
- ☐ Dizziness
- ☐ Lightheadedness
- ☐ Visual changes
- ☐ Hearing problems
- ☐ Ringing in the ears
- ☐ Postnasal drainage
- ☐ Sinus pressure
- ☐ Snoring
- ☐ Hoarseness
- ☐ Sore throat

Respiratory:
- ☐ Cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Wheezing

Cardiovascular:
- ☐ Chest pain
- ☐ Difficulty breathing with exertion
- ☐ Palpitations
- ☐ Swelling of extremities

Gastrointestinal:
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Food intolerance
- ☐ Vomiting

Genitourinary:
- ☐ Blood in Urine
- ☐ Frequency
- ☐ Groin pain
- ☐ Incontinence
- ☐ Pelvic pain
- ☐ Urgency

Musculoskeletal:
- ☐ Back pain
- ☐ Joint pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Numbness
- ☐ Stiffness
- ☐ Ambulatory support
- ☐ Pain with stairs
- ☐ Developing limp
- ☐ Trouble dressing
- ☐ Locking
- ☐ Clicking/catching
- ☐ Instability

Neurological:
- ☐ Headaches
- ☐ Memory loss
- ☐ Seizures
- ☐ Syncope
- ☐ Tingling
- ☐ Tremor
- ☐ Weakness

Psychiatric:
- ☐ Anxiety
- ☐ Depression
- ☐ Trouble focusing

Endocrine:
- ☐ Excessive Thirst
- ☐ High blood pressure
- ☐ Low blood pressure

Hematology:
- ☐ Abnormal bleeding
- ☐ Enlarged lymph nodes

BAB

Patient name:________________________DOB:__________________Appointment Date:_____________

Past Medical History

☐ Anesthetic complications	☐ GERD/Reflux disease	☐ Phlebitis
☐ Asthma	☐ Gout	☐ Rheumatoid arthritis
☐ Bleeding disorder	☐ Heart Attack	☐ Seizure disorder
☐ Blood clots	☐ Heart disease	☐ Sleep apnea
☐ Cancer	☐ Hepatitis	☐ Stroke
☐ Depression	☐ High blood pressure	☐ Thyroid disease
☐ Diabetes- Type 1 or 2	☐ Hyperlipidemia	☐ Ulcers
☐ Emphysema	☐ Kidney Stone	☐ Other:_____________
☐ Fibromyalgia	☐ MRSA	
	☐ Osteoarthritis	

If the date is unknown, please use approximate month and year

Date of last Influenza immunization:______________________ ☐ **Never**

Date of last Pneumonia vaccination:______________________ ☐ **Never**

Date of COVID-19 vaccination: 1st dose: _____________ **2nd dose:** ______________

Social History

Tobacco: ☐ Never a smoker ☐ Never used tobacco products

Current Smoker: Cigarettes/Vape ☐ Yes ☐ No Amt:________pck/day

Has been smoking for ____________ years.

Vaping ☐with or ☐ without nicotine?

Smokeless Tobacco: ☐ Yes ☐ No Amt:________per day

Cigars: ☐ Yes ☐ No Amt:________# week

☐ Quit Smoking: Last year smoked_____________Amt:________pck/day

How many years did you smoke?_______________Years

Alcohol Use:

☐ Yes ☐ No ______# drinks per day / week / occasional / social

Exercise:

☐ Yes ☐ No Times per week:__________

Occupation: __________________________

Family History

☐ Blood Clots	☐ Father	☐ Mother	☐ Sibling	☐Other____________
☐ Cancer	☐ Father	☐ Mother	☐ Sibling	☐Other____________
☐ Diabetes	☐ Father	☐ Mother	☐ Sibling	☐Other____________
☐ Heart disease	☐ Father	☐ Mother	☐ Sibling	☐Other____________
☐ High blood pressure	☐ Father	☐ Mother	☐ Sibling	☐Other____________
☐ Stroke	☐ Father	☐ Mother	☐ Sibling	☐Other____________

BAB

Patient name:__________________________DOB:____________________ Appointment Date:_______________

CURRENT MEDICATIONS: (Please include over the counter medications and food supplements.)

☐ NONE

Drug Name:___________________________Dose:______________How Often:_______________

Drug Name:___________________________Dose:______________How Often:_______________

Drug Name:___________________________Dose:______________How Often:_______________

Drug Name:___________________________Dose:______________How Often:_______________

Drug Name:___________________________Dose:______________How Often:_______________

Drug Name:___________________________Dose:______________How Often:_______________

Drug Name:___________________________Dose:______________How Often:_______________

Drug Name:___________________________Dose:______________How Often:_______________

Drug Name:___________________________Dose:______________How Often:_______________

Drug Name:___________________________Dose:______________How Often:_______________

List all **ALLERGIES** to any medications, **LATEX** or **TAPE** and the reactions:

☐ **No Known Drug Allergies**

Medication	Reaction

Past Surgical

Please list all of the **SURGERIES** you have had:

Type of Surgery	Year	Type of Surgery	Year

Have you ever had any **NECK** or **BACK** imaging? (Xray, MRI, CT scan)

Type of Imaging	Month/Year	Type of Imaging	Month/Year

Authorization To Use Or Disclose Protected Health Information

Facility/ Provider/Doctor: ____

Patient Name: _______________________________________**Patient Date of Birth:** ________________________

Recipient and Purpose of Request: I authorize Provider to disclose my protected health information to the following ("Recipient"):
Recipient Name: The Spine Clinic of Oklahoma City- Dr. Brett Braly
For the following purpose: ____

I authorize Provider to use or disclose the following protected health information of the patient described above to recipient described above in a manner consistent with the authorization (check all that apply):

☐ **Entire medical record concerning the patient (excluding psychotherapy notes, if any).**

☐ **Entire billing record concerning this patient.**

■ **Medical record concerning this patient for the following date(s) of service:** _______________

■ **Billing record concerning this patient for the following date(s) of service:** ________________

☐ **Other:** ____

I understand the following:

- Protected health information is health information that identifies me. The purpose of this authorization is to allow Provider to share my protected health information as set forth above.
- I understand that this authorization is voluntary and that I have the right to refuse to sign this authorization. If I refuse, my protected health will not be used or disclosed by provider except as otherwise permitted by law. Provider may not condition treatment on my providing this authorization for use or disclosure of my medical information. If I refuse to sign this authorization, I will still be eligible to receive medical services from provider.
- Subject to certain exceptions, I have the right to revoke this authorization at any time by sending a letter to provider which gives my name, the date I signed the authorization, and the state that I revoke the authorization to use my protected heath information. The letter will not affect any actions taken in reliance of my previous authorization.
- This authorization may result in Provider disclosing my medial information to a recipient who could possible later use or disclose the information without my authorization. Provider cannot control re-disclosure by Recipient.
- I may inspect or copy the information that will be disclosed or used for the purposes set forth in this authorization. I will receive a signed copy of this authorization form and may contact Provider to get a copy if I do not have one.
- Protected health information authorized for release may include records that indicate the presence of or regarding treatment of HIV/AIDS, sexually transmitted disease, and drug and/or alcohol abuse.

____
Signature of Patient or Patient's Represent

Date: ______________________

____
Printed Name of the Patient or Patient's Representative

Descriptions of Representative authority (attach documentation):

☐ **Parent of minor** ☐ **Legal Guardian** ☐ **Power of attorney**
☐ **Other:** ____________________________________

This authorization is only effective if it is signed and dated. Unless I revoke this authorization prior to expiration, this authorization expires on ____________________ **(or if this is left blank, one year after the date it is signed).**