OKLAHOMA SPORTS SCIENCE AND ORTHOPAEDICS, P.L.L.C.

6205 North Sante Fe • Oklahoma City, Oklahoma 73118 • (405) 427-6776 • FAX (405) 419-5475

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NEW PATIENT INFORMATION

(Please Print - Fill in All Blanks)

PATIENT'S LEGAL NAME: LAST FIRST MIDDLE INITIAL | SEX: | BIRTH DATE: | AGE

SOCIAL SECURITY NO.: | MARITAL STATUS: ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

PATIENT'S ADDRESS: | Are You: ❑ Employed ❑ Full-Time Student ❑ Part-Time Student ❑ Retired

CITY: | STATE: | ZIP CODE: | REFERRING PHYSICIAN:

HOME PHONE: ( ) | WORK PHONE: ( ) | CELL PHONE: ( ) Is it okay to leave a message on phone number provided? ❑ Yes ❑ No

INSURANCE INFORMATION - We will need a copy of the Insurance Card in order to file a claim.

Name of the Primary Insurance Company _____

Name of the Person who carries the Insurance Policy _____ Relationship to Patient _____

Carriers DOB _____ Carriers SS#_____

Carriers Employer _____

Secondary Insurance _____

Carrier Name _____ Relationship to Patient_____

Not Applicable ❑ Carriers DOB _____ Carriers SS#_____

Carriers Employer _____

EMPLOYMENT INFORMATION

N/A ❑ Patients Employer _____ Ph# _____

N/A ❑ Insured Employer _____ Ph# _____

If the patient is a minor, please list both parents names and employer

Mother _____ Employer _____ Ph# _____

N/A ❑ Father_____ Employer _____ Ph# _____

EMERGENCY CONTACT

NEAREST RELATIVE NOT LIVING WITH YOU:

HOME PHONE: ( ) | RELATIONSHIP TO THE PATIENT:

WHO REFERRED YOU TO OUR OFFICE?

❑ Adjustor ❑ Attorney ❑ Billboard ❑ Case Manager ❑ Coach ❑ Doctor ❑ Employer ❑ Family ❑ Friend ❑ Hospital
❑ Insurance Co. ❑ Magazine ❑ Neighbor ❑ Newspaper ❑ Phone Book ❑ Physical Therapist ❑ Radio ❑ School ❑ Trainer

THIRD PARTY BILLING

Is Your Injury Work Related?	❑ Yes	❑ No
Is This Injury Due To A Motor Vehicle Accident?	❑ Yes	❑ No
If Your Injury Is MVA Related Have You Obtained an Accident Report?	❑ Yes	❑ No

I hereby authorize my insurance benefits to be paid directly to the facility and the physician and 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 and agree that I have received a copy of the TPG Privacy Notice.

Signature Date

AUTHORIZATION FOR TREATMENT

I hereby authorize the Physician(s) in charge of the care of the patient of Oklahoma Orthopedic & Sports Science Physicians' 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 Orthopedic & Sports Science Physicians' 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 Orthopedic & Sports Science Physicians' 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 organizations, workers compensation carriers, welfare funds, the Social Security Administration or its 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 KNOWN 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 Orthopedic & Sports Science Physicians', it agents and it employees from liability in connection with the release of the information contained therein.

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 Orthopedic & Sports Science Physicians'. 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 for 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 Orthopedic & Sports Science Physicians' from any claim for responsibility or damages in the event of loss of my property, including money and jewelry.

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

SIGNED _____ **DATE** _____
(PATIENT)

WITNESS
OR _____ **TO SIGNATURE** _____
(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 a 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 health care 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 Department of Health, or by law.

Name:_____ Date: _____

Are you here for a second opinion? ❑ Yes ❑ No

Date of Injury: _____ Date Symptoms Began: _____

Were you injured on the job? ❑ Yes ❑ No

If yes, how did injury happen _____

Where?_____ What time? _____

Have you been treated before for this injury? ❑ Yes ❑ No

Were x-rays or tests done? ❑ Yes ❑ No

Did you bring them or a report with you? ❑ Yes ❑ No

Able to continue activity or work: ❑ Yes ❑ No

If unable to work, please give date of last day worked _____

Location of pain (i.e., shoulder, knee, etc.): _____ Circle Lt. Rt.

Diagnosis given:_____ Treatment given:_____

Was surgery performed? ❑ Yes ❑ No (If so, please obtain operative report or notify the receptionist so she may obtain a copy for our records.)

Date of surgery:_____ Surgery performed:_____

List all previous surgeries (name and approximate date)

1. _____ 2. _____

3. _____ 4. _____

List any medications you are currently taking and how you take them.

1. _____ 2. _____

3. _____ 4. _____

Drug allergies? ❑ Yes ❑ No HEIGHT _____ WEIGHT _____

1. _____ 2. _____

3. _____ 4. _____

Have you ever had (Please circle Y for yes and N for no)?

Heart trouble, attack, angina	Y	N	High blood pressure	Y	N
Abnormal EKG	Y	N	Stroke	Y	N
Emphysema, other lung or breathing problems	Y	N	Jaundice, hepatitis, mono	Y	N
			Abnormal bleeding tendencies	Y	N
Epilepsy or seizures	Y	N	Blood disease (Anemia, etc.)	Y	N
Glaucoma	Y	N	Facial bone fractures	Y	N
Blood thinners	Y	N	Paralysis	Y	N
Kidney disease	Y	N	Diabetes	Y	N
Neck or back trouble	Y	N	Cancer	Y	N
Muscle weakness	Y	N	Positive HIV/Aids test	Y	N
Blood vessel disease	Y	N	Ulcers	Y	N
Arthritis	Y	N	Thyroid dx	Y	N
Do you smoke?	Y	N	Could you be pregnant?	Y	N
Packs/day _____					

Signature _____

Oklahoma Sports Science & Orthopaedics

- The pain you are experiencing may be improved, but not eliminated, with the use of narcotic pain medication.
- Once pain medications are prescribed you will be required to have regular office visits to assess your pain status. Your medications will not be phoned in should you be unable to keep these appointments.
- This office fills pain medications for surgical patients only. They are not filled indefinitely. After a period of time your doctor will taper your medications for discontinuation. If discontinuation is not possible or you are not a surgical candidate you will be referred for long-term pain management.
- Your treating physician is to be the only physician who prescribes narcotic pain medications to you.
- It is your responsibility to notify us of any other physician who is prescribing narcotic pain medications to you. It is also your responsibility to inform other physicians that we are prescribing and managing you narcotic pain medications.
- Individuals must be aware that " doctor shopping " is viewed as narcotic drug seeking behavior and is not tolerated. Should this type of behavior occur, your narcotic pain medications will not be refilled and you will be dismissed as a patient.
- Excessive calls requesting pain medications or an increase in the dose or frequency of your pain medications is viewed as drug seeking behavior and is not tolerated. You will be asked to make an appointment to see the doctor before any changes are made.
- Pain medication refill requests are taken and called in MONDAY thru FRIDAY from 8:30 am to 3:30 pm ONLY. PRESCRIPTION REFILLS ARE NOT TAKEN OR CALLED IN ON SATURDAY, SUNDAY, HOLIDAYS, OR AFTER HOURS FOR ANY REASON. We guarantee prescription refills will be processed within 48 hours of the request.
- Federal and state law carefully regulates dispensed or written prescriptions for narcotic medications. Forging or altering a narcotic prescription, or distributing medications to others of their use or for money, is a crime. Such behavior is not tolerated. You will be dismissed as a patient and be reported to the DEA, Police and FDA.
- Lost, stolen, or misplaced prescriptions or medications ARE NEVER REPLACED- NO EXEPTIONS. Your medications and prescriptions are your responsibility.
- Narcotic pain medications may cause sedation and dizziness. You should not drive an automobile nor operate any machinery when taking medications.

Informed consent: I,_____, have been informed and clearly understand the above listed issues regarding the treatment of pain with narcotic pain medications. I understand that this agreement will be filed in my chart as a part of my permanent medical record.

Signature_____ Date_____

Oklahoma Sports Science & Orthopaedics

A division of The Physicians' Group

Financial Policy

Thank you for choosing "Oklahoma Sports Science & Orthopaedics" as your healthcare provider. At OSSO we are dedicated to providing the highest quality, most cost effective care specializing in Adult & Pediatric Orthopedics, Sports Medicine, Running Injuries, Physical Medicine and Rehabilitation, Pain Management, Reconstructive & Orthopedic Spine Surgery and Hand Surgery.

In additional to accepting traditional insurance plans and Medicare we are contracted with numerous, 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 to each appointment your current insurance card, or any other information that is required by your insurance carrier. 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 Card, American Express or MasterCard. We do have a payment plan for patients who have financial concerns. Please notify our office at 427-6776 to make payment arrangements. **Please be aware that charges 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 you will be set up on a self-pay account for any charges incurred up to $500.00. If charges exceed $500.00, 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 $35.00 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 at Saints North 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 & Staff

My signature below acknowledges receipt of this Financial Policy:

Signed: _____Date_____
(Signature of person financially responsible for payment)

Relationship if other than patient: _____

By Oklahoma Statute, we may charge you $1.00 for the first page and $.50 per page for each additional page. If your record contains any item that requires a photographic process to copy, such as a x-ray or photograph, we may charge you $5.00 per image.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by our facility. To request an amendment, your request must be made in writing and submitted to the medical records office. In addition, you must provide a reason that supports your amendment request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Is not part of the medical information kept by our facility
- Is not part of the information which you would be permitted to inspect or copy
- In our judgement is accurate and complete as it appears.
- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we have made of your medical information. To request this list of disclosures, you must submit in writing to Release of Information in our office. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list. The first list you request within each 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time, before any costs are incurred.

Right to Request Restrictions: You have the right to request a restriction or limitation on the protected medical information we use or disclose about you for treatment, payment or healthcare operations. We must receive your restrictions in writing before we have made such disclosures. Also, if you restrict our right to use your protected medical information for treatment, payment or healthcare operations, we reserve the right to immediately withdraw our services from you and terminate the physician-patient relationship. You have the right to request a limit on the protected medical information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend.

For example, you could ask that we not use or disclose information about a surgery to your family. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment. To request restrictions, you must make your request in writing to the receptionist in our facility. If you request restrictions, you must tell us what information you want to limit, whether you want to limit our use and/or disclosure and to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work, or at home, or by mail, or by phone or by e-mail. To request confidential communications, you must make your request in writing to the receptionist in our office. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Copy of this Notice: You have the right to a copy of this notice. You may ask us to give you a copy of this notice at any time.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for protected medical information we already have about you as well as any information we receive in the future. We will post a copy of the current notice in our office. The notice will contain the effective date.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our facility, please contact the Privacy Officer at (405) 419-8438. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of protected medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose protected medical information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose protected medical information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

H·P·I·
Healthcare Partners Investments, LLC

Northwest Surgical Hospital
An Affiliate of HPI, LLC

NW OpenMRI
An Affiliate of Northwest Surgical Hospital

LakePointe Imaging Center
An Affiliate of Northwest Surgical Hospital

An Affiliate of HPI, LLC
Community Hospital

AccuHealth
An Affiliate of HPI, LLC

St. Anthony Bone & Joint®
An Affiliate of HPI, LLC

St. Anthony North Ambulatory Surgery Center
An Affiliate of HPI, LLC

OSSO
Oklahoma Sports Science & Orthopaedics

Rev. 092404

TPG
THE PHYSICIANS' GROUP

Patient Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE PLEASE CONTACT OUR RECEPTIONIST.

WHO WILL FOLLOW THIS NOTICE

This notice describes our facility's practices and that of:

- All employees, staff and other personnel
- Any health care professional authorized to enter information into your file or record
- All entities, sites and locations within ***The Physicians Group*** follow the terms of this notice. In addition, these entities, sites and locations may share medical information with each other for treatment, payment or healthcare operations purposes described in this notice.

Effective April 14, 2003

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. We create a record of the care and services you receive in our facility. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of your care. This notice will tell you about the ways in which we may use and disclose medical information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of medical information. We are required by law to:

- Make sure that medical information that identifies you is kept private
- Follow the terms of the notice that is currently in effect
- Give you this notice of our legal duties and privacy practices with respect to protected medical information about you.

HOW WE MAY USE AND DISCLOSE YOUR MEDICAL INFORMATION

The following categories describe different ways that we use and disclose protected medical information. For each category of uses or disclosures we will explain what we mean. Not every use or disclosure in a category will be listed. However, all of the ways are permitted to use and disclose information will fall within one of the categories.

For Treatment: We may use protected medical information about you for medical treatment or services. We may disclose protected medical information about you to doctors, nurses, technicians, medical students, pharmacists or other personnel who are involved in your care. Different departments of our practice also may share medical information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose protected medical information about you to people outside the practice who may be involved in your medical care, such as family members or others we use to provide services that are part of your care.

For Payment: We may use and disclose protected medical information about you so that the treatment and services you receive may be billed to and payment may be collected for you, an insurance company or a third party. For example, we may need to give the information about the treatment you received to your health plan, so that your health plan will pay us or reimburse you. We may tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

We may use and disclose your information to obtain payment from third parties that may be responsible for such costs, such as family members. We may use your information to bill you directly for services and items.

Appointment Reminders: We may use and disclose protected medical information to contact you as a reminder that you have an appointment for treatment or medical care.

Treatment Alternatives: We may use and disclose protected medical information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Benefits and Services: We may use and disclose protected medical information to tell you about health-related benefits and services that may be of interest to you.

Individuals Involved in Your Care or Payment for Your Care: We may release protected medical information about you to a designated friend or family member who is involved in your medical care. We may give information to someone who helps pay for your care. In addition, we may disclose protected medical information about you to an entity assisting in a disaster relief effort, so that your family can be notified about your condition, status or location.

Research: Under certain circumstances, we may use and disclose protected medical information about you for research purposes. All research projects are subject to a special approval process. The process evaluates a proposed research project and its use of your information, trying to balance the research needs with patients need for privacy of their medical information. However, we may disclose medical information about you to people preparing to conduct a research project, though we will ask for your specific permission to give a researcher your name, address or other information that reveals your identity. In rare cases, your permission may be waived as directed by federal, state and local law.

As Required by Law: We will disclose protected medical information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety: We may need to use and disclose protected medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure would only be to someone able to prevent the threat.

SPECIAL SITUATIONS

Organ and Tissue Donation: If you are an organ donor, we may release protected medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans: If you are a member of the armed forces, we may release protected medical information about you as required by military command authorities. We may also release protected medical information to a foreign military authority, if you are in their service.

Workers' Compensation: We may release protected medical information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness. State and/or federal law control release of such information.

Public Health Risks: We may disclose protected medical information about you for public health activities. These activities include the following:

- To prevent or control disease, injury or disability
- To report births and deaths
- To report a known or suspected crime
- To report child abuse or neglect
- To report vulnerable adult abuse
- To report reactions to medications or problems with products
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition
- To notify the appropriate government authority if we believe a patient has been the victim of domestic violence. We will only make this disclosure if you agree or when required or authorized by law

Health Oversight Activities: We may disclose protected medical information to a health oversight agency for activities authorized by law. These oversight activities include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose protected medical information about you in response to a subpoena, discovery request or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement: We may release protected health information if asked to do so by a law enforcement official:

- In response to a court order, subpoena, warrant, summons or similar process
- To identify or locate a suspect, fugitive, material witness or missing person
- About a death we believe may be the result of criminal conduct
- About criminal conduct involving our facility
- About the victim of a crime, if we are unable to obtain the person's agreement
- In emergency circumstances to report a crime, the location of the crime or victims and/or the identity, description or location of the person who committed the crime

Medical Examiners and Funeral Directors: We may release protected medical information to a medical examiner. This may be necessary to identify a deceased person or to determine the cause of death. We may also release medical information about patients to funeral directors as necessary to carry out their duties.

National Security, Intelligence and Federal Protective Service Activities: We may also release protected medical information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law. We may release information to authorized federal officials where required to provide protection to the President of the United States, other authorized persons or foreign heads of state and/or conduct special investigations.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected medical information about you to the correctional institution or law enforcement official. The release of this information would be necessary for this practice to provide you with healthcare, to protect your health and safety or the health and safety of others and for the security of the correctional institution.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding protected medical information we maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes medical and billing records, but does not include psychotherapy notes. To inspect and/or copy your medical information you must submit your request to Release of Information in our office. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request.

Oklahoma Sports Science and Orthopaedics

Patient Name_____
DOB_____
Date_____

Name of the physician you are seeing here today_____

How did you hear about our office? (please circle)

Athletic Trainer Attorney Coach Workers Comp Adjuster
Workers Comp Case Manager Employer Friend Family
Hospital Insurance Co Magazine Phone Book Radio
Television School Doctor

Did an athletic trainer refer you to us? Yes No
If so please list their name and the school you attend

Name_____
School_____

Who is your Family Physician?

Name_____
Phone_____

Did your Family Physician refer you to us? Yes No

Did another Physician refer you to us? Yes No
If so please list their name and phone number

Name_____
Phone_____

If you are seeing us due to a Workers Comp Injury do you have a Case Manager assigned to your case? If so please list their name and phone number

Name_____
Phone _____

The Physicians Group

OSSO

OKLAHOMA SPORTS SCIENCE & ORTHOPAEDICS

PATIENT AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Date: _____

Address: _____ Phone: _____

Social Security # _____ DOB: _____

Please Release My Medical Records To: Fax: _____

Name: _____ Phone: _____

Address: _____ Contact Person: _____

for the following purposes: _____

_____

By checking the spaces below, I specifically authorize the use or disclosure of the following information and/or medical records, if such information and/or records exist:

- ❑ Please send the entire medical record (all information)
- ❑ Clinic Office Notes
- ❑ Laboratory Reports
- ❑ Radiology Reports
- ❑ Hospital Records
- ❑ Physical Therapy
- ❑ Billing Statements
- ❑ Other: _____

_____

I understand that, if a person or entity receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. Therefore I release The Physicians Group from all liability arising from this disclosure of my health information.

I further understand that the person I am authorizing to use or disclose the information may receive compensation for doing so. I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information to be used or disclosed under this authorization.

Finally, I understand that I may revoke this authorization at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire 6 months from the date of signing or until **(date)** _____

By Oklahoma law, The Physicians Group is required to notify you that the information authorized for release may include records which may indicate the presence of a 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.

_____ _____

Print Patient Name or Name of Legal Representative | Relationship to Patient

_____ _____

Signature of Patient or Patient's Legal Representative | Date

_____ _____

Signature of Witness | Date

6205 North Sante Fe, Suite 200 • Oklahoma City, Oklahoma 73118 • Phone (405) 419-5420 • Fax: (405) 419-5475