GABRIEL M PITMAN, D.O. P.C.
401 SW 80th STREET, #201
OKLAHOM A CITY, OK 73139

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

I understand that as part of my health and medical care, Gabriel M Pitman, DO,PC, originates and maintains medical and health records describing my health history, symptoms, examination and/or 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 care 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 were billed as actually provided
*A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care 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 that I have the right to review the PATIENT PRIVACY NOTICE prior to signing this consent. I understand that Gabriel M. Pitman, DO, PC, reserves the right to change their notice and practices, but that prior to implementation will mail me a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to restrict treatment, payment, or healthcare operations and that Gabriel M Pitman, DO PC, 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 include records that may indicate the presence of a communicable or venereal disease, that my include, but are not limited to, disease such as Hepatitis, Syphilis, Gonorrhea and the Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Because of the new government regulations, we will not be able to discuss health care with anyone but the patient. If you would like for us to be able to give test results etc, to someone else, we must have your permission.

Please list up to three people other than your physician's to whom you would want us to speak with in regards to your health issues.

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1.________________________________ ____________________________

Name Relationship

2.________________________________ ____________________________

Name Relationship

3.________________________________ ____________________________

Name Relationship

_____ I do not want you to speak with anyone other than my physician's about my health issues.

_____ You may leave messages/reports on my voicemail , at this number _________________.

Medical records will not be released to anyone, with the exception of physicians, without a signed release

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Signature of Patient or Legal Representative Date Effective