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## PATIENT AUTHORIZATION FOR TREATMENT AND RELEASE OF INFORMATION

**AUTHORIZATION FOR TREATMENT.** By virtue of my signature, I authorize TOC, and any of its employees or other authorized personnel or agents, to provide general health care services to me.

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION.** I hereby authorize TOC, and any of its employees or other authorized personnel or agents to release any of my medical records or other personal or medical information to any employee, authorized personnel or other agent of any physician, laboratory or diagnostic testing facility, or other healthcare provider involved in my care or treatment for the purpose of developing an appropriate treatment plan or diagnosis, or for purposes of quality assurance, utilization review or other analyses designed to monitor and maintain a quality of care. **IN AUTHORIZING THIS RELEASE OF INFORMATION, I HAVE READ THE NOTICE TO PATIENTS SET FORTH BELOW AND I UNDERSTAND THAT SUCH INFORMATION MAY INDICATE THAT I HAVE OR MAY HAVE A COMMUNICABLE OR VENEREAL DISEASE, INCLUDING BUT NOT LIMITED TO DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, AND THE HUMAN IMMUNODEFICIENCY VIRUS (ALSO KNOW AS ACQUIRED IMMUNE DEFICIENCY SYNDROME OR AIDS).**

> **NOTICE TO PATIENTS:** Any information in your medical record which indicates that you have or may have a communicable or venereal disease, including but not limited to any of the diseases identified above, is deemed confidential information pursuant to Section 1052.2 of title 63 of the Oklahoma Statutes. According to that law, your confidential information cannot be released without your express permission, except in very limited circumstances. Release of such confidential information may be allowed to persons who have been exposed to the risk of infection, pursuant to an order of the court or pursuant to an order of the State Department of Health, or among healthcare providers or agencies for statistical or epidemiological purposes. Even in these circumstances, release may only be allowed if the release can be made without any identifying information.

**PATIENT ACKNOWLEDGMENT.** By virtue of my signature below, I hereby acknowledge that I have read and understand all of the above, and that I have been given adequate opportunity to ask any questions about the same. I understand that I may revoke this authorization at any time, except to the extent that action has already been taken to comply with it. Without my express revocation, this consent will automatically expire upon satisfaction of the need for disclosure.

**SIGNATURE.** By Patient's signature below, Patient represents that Patient is 18 years of age or over and is legally capacitated to give consent to treatment and to authorize release of the above information. By signature of a Parent of Legal Guardian below, such individual represents that Patient is under age 18 (a minor) or has a court-appointed guardian.

_______________________________________ _______________ _______________ PM/AM
Patient's Signature (Adult, capacitated) Date Time

_______________________________________ _______________ _______________
Patient's Name Printed Patient's D.O.B. Patient's SSN

_____________________ _________________ _______________ _______________ PM/AM
Signature of Parent/Legal Guardian Relationship To Patient Date Time

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