4920 SW Lee Blvd.
Lawton, OK 73505
(580) 536-5192

SKIN SECRETS

Dale B. Smith, D.O.

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

I understand that as part of my health and medical care, Skin Secrets originated and maintains medical and health records describing my health history, symptoms, examinations and 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 for communication among the health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment for my bill
- A means for a third-party payer to verify that services were billed as actually provided
- A tool for routine healthcare options such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a **PATIENT PRIVACY NOTICE** that provides a more complete description of information uses and disclosures. I understand that I have right to review the **PATIENT PRIVACY NOTICE** prior to signing this consent. I understand that Skin Secrets reserves the right to change their notices and practices, but that prior to implementation will mail 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 request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Skin Secrets is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent the organization has already taken action I reliance thereon.

This agreement to release further information shall remain in force until such time as I shall revoke in writing.

By Oklahoma law we are required to notify you ….. **that the information authorized for release may include records which may indicate 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 (AIDS).**

By signing this form I also agree to allow **Skin Secrets** to leave appointment reminders and/or medical information with my message service or on my answering machine.

Information may be released to the following individuals or organizations for the indicated purpose:

Name of Person or Organization: Relationship: Purpose for Release:

_____

_____

_____

I request the following restrictions to the use and/or disclosure of my health information:

_____

Patient Signature: _____ Date: _____

This form is being provided to meet HIPPA requirements