

Plastic Surgery Associates Of Tulsa

CONSENT FOR ROUTINE MEDICAL TREATMENT

Plastic Surgery Associates of Tulsa, P.L.L.C., and its employees are hereby authorized to collect medical history information and perform other routine procedures for the purpose of providing care to you. You have the right to consent or refuse consent to any proposed procedure with the exception of emergency circumstances. In the event of an emergency, we will take all necessary actions to meet your medical needs.

CONSENT FOR DISCLOSURE OF INFORMATION

As our patient, we want you to know that we respect the privacy of your personal medical information and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, Plastic Surgery Associates of Tulsa, P.L.L.C. providers and employees may provide the minimum necessary information to only those that are in need of my health care information and information about treatment, payment, or health care operations, in order to provide health care that is in my best interest. We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for the purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent. By signing this agreement, you are consenting to such disclosure. You have the right to refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your personal health information. If you consent to this document, at some time in the future you may request to refuse all or part of your personal health information. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

PATIENT CERTIFICATION

I hereby certify that I have the above statements and had them explained to my satisfaction. I further certify that I am the patient of legally authorized by the patient to accept the terms of this patient agreement. A photocopy of this document has the same effect as the original.

Signature of Patient or Legally Authorized Representative (Documentation must be provided)

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

A complete copy of how your medical information will be used and disclosed by Plastic Surgery Associates of Tulsa, P.L.L.C. is in our Notice of Privacy Practices, which you should read before signing this acknowledgement.

I have received a copy of Plastic Surgery Associates of Tulsa, P.L.L.C. Notice of Privacy Practices.

Patient or Representative

Legal Authority of Representative

Date signed

Basis of refusal, if refused: _____