SURGICAL PARTNERS OF OKLAHOMA

BRADY HAGOOD, M.D. STEPHANIE TAYLOR, M.D. TIM WEAVER, M.D.

RELEASE OF INFORMATION

(We cannot file insurance without a copy of your insurance card(s) for verification of coverage.)

I hereby authorize my physician to furnish my insurance company or its representative or permit my insurance company or its representative to review any information requested with respect to any illness or accident, medical history or copies of hospital and medical records. A copy of this authorization shall be considered as valid as the original document. I hereby authorize payment directly to my physician for this illness or injury, for the physician's benefits otherwise payable to me, but not to exceed my indebtedness to said physician. I agree to pay the physician for all my charges whether or not covered by the assignment. The responsible party hereby agrees that the physician office or the party responsible for the billing of these services may check credit with a source to obtain credit information. I authorize any holder of medical information about me to release any information needed to determine these benefits payable for related services. This release may include information about a medical condition that is considered a communicable venereal disease, including, but not limited to diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS). I understand all of the above and hereby state all the information is correct to the best of my knowledge. My signature indicates that I have read the above and grant the request of authorizations. I have been notified that I may receive services from the Nurse Practitioner or Medical Assistance at this office.

Patient or Authorized Person Signature _____ Date _____

HIPAA CONSENT

I, _____ (patient or authorized person), give permission to Surgical Partners of Oklahoma and/or staff to leave information pertaining to my health including, but not limited to, dates and times of appointments, lab/x-ray results and other information as they feel necessary, on my answering machine and/or e-mail. I understand this could result in unintentional disclosure of my personal health information

Patient or Authorized Person Signature _____ Date _____

If you have any objections to the above, please list _____

I also give permission to Surgical Partners of Oklahoma and/or staff to discuss my health conditions with the following people: (examples: spouse, parent, children, sibling)

Person _____ Relationship _____

Person _____ Relationship _____

Person _____ Relationship _____

Person _____ Relationship _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices posted in our facility describes how Surgical Partners of Oklahoma may use and disclose your medical information and how you can get access to this information. Please review it carefully.

A complete copy of the Facility's Notice of Privacy Practices is posted in the office. By signing below, you acknowledge the Facility's Notice of Privacy Practices has been made available to you and a copy will be provided to you at your request.

Patient or Authorized Person Signature _____ Date _____

If authorized person, relationship to patient _____