Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Olsen Orthopedics may use and disclose **protected health information** about me to carry out **treatment, payment and healthcare operations**. Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Olsen Orthopedics reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Practice Privacy Officer:

Name of Privacy Officer: Andrea Wiliamson Practice: Olsen Orthopedics

Address: 1140 S. Douglas Blvd Midwest City, OK 73130

Telephone
With my consent, Olsen Orthopedics may call my home or another designated location and leave a message (on voice mail, answering machine or in person) in reference to any items that assist the practice in carrying out treatment, payment and healthcare operations. This may include appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory and other results.

Mail
With my consent, Olsen Orthopedics may mail to my home or another designated location any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder cards, correspondence and billing statements.

Email
With my consent, Olsen Orthopedics may e-mail to my home or another designated location any items that assist the practice in carrying out treatment, payment and healthcare operations such as appointment reminder cards, correspondence and billing statements.

I have the right to request that Olsen Orthopedics restrict the use or disclosure of my protected health information to carry out treatment, payment and healthcare operations. (Please request for.)

I understand that the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I consent to the use and disclosure of my protected health information to carry out treatment, payment and healthcare operations by Olsen Orthopedics.

I may revoke my consent in writing except to the extent that the practice has already made disclosures based upon my prior consent. If I do not sign this consent, Olsen Orthopedics may decline to provide treatment to me.

______________________	______________________	______________________
Print Patient's Name	Signature of patient *or legal guardian	Date

**Attention Privacy Officer: *If a patient wishes to limit how they are contacted by our practice or the release of their information, please refer the patient to the form titled Request for Limitations and Restrictions of PHI.*