Lawton Community Health Center

CONSENT/RELEASE

AUTHORIZATION FOR MEDICAL TREATMENT AND MEDICATION HISTORY

Lawton Community Health Center and its Medical/Behavioral Health Staff are hereby authorized to administer any medical, diagnostic therapeutic or behavioral health treatment as may be deemed necessary or advisable. I further authorize Lawton Community Health center to request electronic copies of my medication history when deemed relevant to my care. I have the right to consent or refuse consent, to any proposed procedure or therapeutic course, absent emergency or extraordinary circumstances.

DISCLOSURE OF INFORMATION

I understand that all medical records and billing information are made and retained by Lawton Community Health Center and are accessible to clinic personnel and medical staff. Clinic personnel and physicians in attendance may use and disclose medical information for clinic operations and functions and to any other physician or health care personnel involved in the continuum of care. Safeguards are in place to discourage improper access. Lawton Community Health Center is authorized to disclose all or part of my medical record to any insurance carrier, workers compensation carrier, or self-insured employer group liable for any part of Lawton Community Health Center charges and to any health care provider who is or may become involved with my care. Oklahoma law requires that Lawton Community Health Center advise you that the information used for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to Hepatitis, Syphilis, Gonorrhea, Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (Aids). By signing this agreement, you are consenting to such disclosure.

ASSIGNMENT OF INSURANCE BENEFITS

I agree benefits for Lawton Community Health Center charges payable to the insured are to be made payable to Lawton Community Health Center for my care. Any payment received for this period may be applied to any unpaid bills for which I am liable, subject to the rules of coordination of benefits.

PRECERTIFICATION POLICY

I understand that Lawton Community Health Center will assist with insurance precertification requirements which are the responsibility of the policyholder and/or physician, but will not assume responsibility for precertification or any impact which it may have on insurance payment.

FINANCIAL RESPONSIBILITY

As consideration for the services provided me, payment is guaranteed for any amount due for such services provided by Lawton Community Health Center.

CERTIFICATION

I hereby I have read each of the above statements, have had each item explained to me to my satisfaction, and may receive a copy of this Consent/Release upon request. I further certify that I am the patient or duly authorized by the patient to accept the terms of this Consent/Release. A photocopy of this document has the same effect as an original.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

A brief description of how your medical information will be used and disclosed by this facility is in our NOTICE OF PRIVACY PRACTICES, which you should read before signing this agreement. A copy is included in your registration packet and is posted thorough out the clinic.

_____ _____ _____

Patient or Responsible Party | Relationship | Date Signed

_____

Witness

Basis for refusal, if refused: _____