

# Oklahoma Interventional Pain Management

## AUTHORIZATION FOR TREATMENT

I hereby authorize the Physician(s) and the staff in charge of the care of the patient of Oklahoma Interventional Pain Management to administer treatment as may be deemed necessary or advisable in the diagnosis and treatment of this patient.

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I understand that as part of my health and medical care Oklahoma Interventional Pain Management originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I further understand this information serves as: a basis for planning my care and treatment; a means of communication among the health professionals who contribute to my care; a source of information for applying my diagnosis and treatment information to my bill; a means for third-party payer to verify that services were billed as actually provided; and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals. **I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release future information shall remain in force until such time as I shall revoke it in writing.** By Oklahoma law we are required to notify you **that the information authorized for release may include records which may indicate the 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).** With this knowledge, I give my consent to the release of all information in my medical records, including any information concerning identity, and release Oklahoma Interventional Pain Management, its agents, and its employees from liability in connection with the release of the information contained therein.

In addition, I authorize the following person(s) access to any and all of my medical information including, but not limited to, appointment information, procedure information, etc. This release shall remain in force until such time as I shall revoke it in writing.  NONE

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone Number: \_\_\_\_\_

## ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize payment directly to my physician(s) of the medical insurance benefits otherwise payable to me for services rendered during my visit at Oklahoma Interventional Pain Management. I understand I am financially responsible for charges not covered by this assignment. I understand a photocopy of this document is as valid as the original.

## ACKNOWLEDGMENT OF PATIENT PRIVACY NOTICE

I understand and have been provided with a patient privacy notice that provides a description of information uses and disclosures.

Patient Name (PRINT) : \_\_\_\_\_

\_\_\_\_\_  
Patient Signature Date: \_\_\_\_\_

**OR**

\_\_\_\_\_  
Legal Guardian Date: \_\_\_\_\_