DR. PARRINGTON, DR.FREEMAN & DR. LAM
13901 McAuley Blvd, Ste. 220
OKLAHOMA CITY, OK 73134
(405) 755-6102 FAX (405) 755-6140

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

Before using or disclosing your child's protected health information to carry out treatment, payment or healthcare operations, we are requesting your consent. By signing the consent, you agree that we may use or disclose your child's protected health information to carry out treatment, payment or healthcare operations.

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.

I understand and have been provided with a PATIENT PRIVACY NOTICE that provides a more complete description of information, uses and disclosures. I understand that I have the right to review the PATIENT PRIVACY NOTICE prior to signing this consent. I understand that Dr.'s Parrington, Freeman, and Lam reserve the right to change their notice and practices and that I will be provided a copy of any revised notice upon my request. I understand that I have the right to request restrictions as to how my child's health information may be used or disclosed to carry out treatment, payment or healthcare operations and that Dr.'s Parrington, Freeman, and Lam are not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

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).

In addition to the release outlined above, information may be released to the following individuals/organizations for the indicated purpose.

_____ _____

_____ _____

I request the following restrictions to the use and/or disclosure of my health information:

_____

_____

I have read this consent and I understand and agree with its terms

_____ _____

Patient Name (please print) Parent Signature/Date

_____ _____

Authorized Representative/Date Account Number

Dr.'s Parrington, Freeman, and Lam____accepts ____denies conditionally the restrictions imposed on release of information as stated above.