OLIVE BRANCH
CLINIC

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

Please read through this consent & verify that you understand by checking the boxes & placing your initials at the bottom of the page.

18 years or older

☐ I, _____ authorize this clinic to provide professional outpatient counseling and psychiatric services to myself. I am aware that these services may include medication management and/or counseling. I understand that part of treatment William Oliva MD originates and maintains medical and health records that will contain my health history, symptoms, examination, test results, diagnosis, medication & regiment, treatment, and any plans for future care/treatment. I understand that medical and health records will be predominantly kept in electronic form. I further understand that this information serves as a basis for planning care, a means of communication among health professions 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 services were provided, and a tool for routine healthcare operations such as accessing quality reviewing the competence of healthcare professions. These consents will remain in effect until further notified.

Minor

☐ I, _____ as the **parent/guardian** authorize this clinic to provide professional outpatient counseling and psychiatric services to the **minor** _____. I am aware that these services may include medication management and/or counseling. I understand that part of treatment William Oliva MD originates and maintains medical and health records that will contain this minor's health history, symptoms, examination, test results, diagnosis, medication & regiment, treatment, and any plans for future care/treatment. I understand that medical and health records will be predominantly kept in electronic form. I further understand that this information serves as a basis for planning care, a means of communication among health professions who contribute to the above minor's care, a source of information for applying his/her diagnosis and treatment information to my bill, a means for third party payer to verify services were provided, and a tool for routine healthcare operations such as accessing quality reviewing the competence of healthcare professions. These consents will remain in effect until further notified.

Initials: _____

OLIVE BRANCH
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PATIENT NAME: _____

ASSIGNMENT OF BENEFITS:

☐ I hereby authorize that services rendered at this clinic and/or by the above psychiatrist shall be allowed to contact my private insurance company/companies and their review agencies and/or Medicaid to verify benefits & eligibility, submit claims, submit for prior authorization and/or receive payment.

CONSENT FOR DISCLOSURE OF MEDICAL RECORDS:

☐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. William Oliva reserves the right to change the PATIENT PRIVACY NOTICE and practices and will provide notification in writing prior to the changes being implemented.

☐ I hereby authorize Dr. William Oliva to release my information, including initial intake, evaluation(s), assessment(s), diagnosis, progress notes, prognosis, dates of services and/or treatment information to my private insurance company/companies and/or legal representatives, and/or Medicaid. Any disclosure of my records shall be limited to information that is reasonably necessary for the payment, discharge of the legal or contractual obligations of the insurance company/companies and/or Medicaid. I understand the information obtained by use of this authorization may also be utilized to determine appropriateness of services provided to me per the requirements of my third party payer source.

☐ I 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 place until such a time I submit a written request to revoke this consent.

☐ I understand that I have the right to object to the use of my health information for directory purposes.

☐ I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, and/or health care operations. I am aware that William Oliva MD is not required to agree to the restrictions requested if I have not provided in writing a revocation of consent. This revocation does not apply to action that was taken prior to revocation of consent.

☐ 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 not limited to diseases such as hepatitis, syphilis, gonorrhea, the Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS).

Date: _____

_____

Signature of ☐ Parent ☐Guardian ☐Patient 18 yrs or older ☐Other (specify)_____

_____

Witness Signature

Dr Oliva's use only: ☐ Accepts Consent ☐Denies Consent ☐Accepts Conditionally ☐Restrictions imposed