Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations** and DISCLOSURE OF PHYSICIAN OWNERSHIP NOTICE TO PATIENTS OF ORTHOPAEDIC AND SPORTS SPECIALISTS,P.C.

I understand that as part of my health and medical care, ORTHOPAEDIC & SPORTS SPECIALISTS, P.C. originates and maintains electronic medical and health records, describing, but not limited to my health history, symptoms, physician examination, medications, x-ray and/ or radiology test results (such as MRI, CT scan, EMG/NCT, or Arthrogram) , EKG reports, operative reports, diagnoses, current treatment, disability status, functional capacity evaluations, durable medical goods ordered, plans for future care or treatment, as well as a permanent disability rating if so required. I further understand that 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 a 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 understand that I can have secure access to my health records electronically by viewing my health record at viewmyhealthrecords.com. The pamphlet explaining how to access my electronic health records can be obtained from the office staff of ORTHOPAEDIC AND SPORTS SPECIALISTS, P.C. If I do not wish to view my records electronically, I am aware that I may request , in writing, that ORTHOPAEDIC AND SPORTS SPECIALISTS, P.C. reproduce a copy of my health record. The office staff will supply a form to be completed to ensure that I receive the medical records which I require.

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 ORTHOPAEDIC & SPORTS SPECIALISTS, P.C. reserves the right to change their notice and practices. Prior to implementation, as a current treating patient, I will receive and be required to sign a copy of any revised notice . 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, or healthcare operations and that ORTHOPAEDIC & SPORTS SPECIALISTS. P.C. is 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).**

Name of Patient_____ Date of Birth_____

In addition to the releases 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:_____

_____

You ____ may _____ may not leave (appointment reminders) (medical information) on my message service or machine.

You ____ may _____ may not fax information to me. My fax number is: _____

You ____ may _____ may not contact me by E-mail. My E-mail address is: _____@_____

_____ _____

Signature of Patient or Legal Representative Date Notice Effective

ORTHOPAEDIC & SPORTS SPECIALISTS, P.C._____ accepts _____ denies _____ accepts conditionally the restrictions imposed on release of information as stated above.

_____ _____

Orthopaedic Employee Signature and Title Date

As a prospective patient of Oklahoma Center of Orthopaedic and Multi-Specialty Surgery and OCOM Imaging it is our responsible to inform you of the following:

1. Mark F. Kowalski, M.D. has an ownership interest in Oklahoma Center of Orthopaedic and Multi-Specialty Surgery and OCOM Imaging.
2. In addition, other physicians that may treat you at the hospital or imaging center(s) may have an ownership in the facilities.
3. You have the right to choose the provider of your health care services. Therefore, you have the option to use a healthcare facility other than Oklahoma Center of Orthopaedic and Multi-Specialty Surgery and OCOM Imaging. You will not be treated differently by Dr. Mark Kowalski or his staff if you choose to use a different facility. If desired, our office can provide information about alternative providers that are available. We welcome you as a patient and value our relationship with you. If you have any questions concerning this notice, please feel free to ask our office manager.

By signing this Disclosure of Physician Ownership, you acknowledge that you have read and understand the foregoing notice and understand that your physician, Mark F. Kowalski, M.D. has an ownership interest in the above named entities.

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Signature of patient or Signature of patient's legal guardian or representative Date