Oklahoma Medical Research Foundation
Multiple Sclerosis Center of Excellence
820 NE 15th Street
Oklahoma City, OK 73104
405-271-6242
Fax 405-271-2887
omrf.org/MS Center

Consent to the Use and Disclosure of Health Information for Treatment, Payment and/or Healthcare Options

GABRIEL PARDO, M.D.
CHELSEA BERKLEY, M.D.
ANTHONY (TONY) SHARP, PA-C
JENNIFER SMITH, PA-C
BOBBETTE MILLER, DPT, NCS

I understand that as a part of my health and medical care, Gabriel Pardo, M.D., Chelsea Berkley, M.D., Bobbette Miller, DPT, NCS, Anthony (Tony) Sharp, PA-C, and Jennifer Smith, PA-C originate and maintain medical and health records describing my health history, symptoms, examination(s) and/or test results, diagnoses, treatment(s), and any plans for future care or treatment. I further understand that this information serves as:

- A basis for planning my care and treatment(s).
- 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.
- 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.

I understand that I have the right to review the *PATIENT PRIVACY NOTICE* prior to signing this consent form. I understand that Gabriel Pardo, M.D., Chelsea Berkley, M.D., Anthony (Tony) Sharp, PA-C, Jennifer Smith, PA-C and Bobbette Miller, DPT, NCS, reserve the right to change their notice and practices, but that prior to implementation, they will mail a copy of any revised notice to the address I have provided. I understand that I have the right to request restrictions as to how my health information may be used and disclosed. I understand that I have the right to request treatment, payment, or healthcare operations and that Gabriel Pardo, M.D., Chelsea Berkley, M.D., Bobbette Miller, DPT, NCS, Anthony (Tony) Sharp, PA-C, and Jennifer Smith, PA-C 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 that may include, but are not limited to, diseases such as Hepatitis, Syphilis, Gonorrhea and Human Immunodeficiency Virus, also known as Acquired Immune Deficiency Syndrome (AIDS).

Because of new government regulations, we will not be able to discuss health care with anyone but the patient. If you would like for us to be able to give test results etc, to other parties, we must have your permission. Please see the back of this page to designate those to whom we may disclose information.

_____ _____

Signature of Patient or Legal Representative Date

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Please list up to three people other than your physician(s) to whom you grant your permission for us to speak with regarding your health issues.

1. _____ _____
Name Relationship

Contact Phone Number _____

2. _____ _____
Name Relationship

Contact Phone Number _____

3. _____ _____
Name Relationship

Contact Phone Number _____

_____ I do not want you to discuss my health issues with anyone other than my physician(s).

This release will remain in effect until changed by the patient *in writing*.

_____ _____
Signature of Patient or Legal Representative Date Effective

I have read and understand the above statements.

_____ _____
Signature of Patient or Legal Representative Date Effective

(Revised 8/2017 ts)