Brian Roadhouse, D.C.
6565 S. Yale Ave., Suite 106
Tulsa, Oklahoma 74136-8310

Authorization for Consent of the Use or Disclosure of Information for Purposes of Treatment, Payment & Healthcare Operations Requested by Dr. Brian Roadhouse (03/03)

I consent to the use or disclosure of my protected health information by Dr. Brian Roadhouse's office for the purpose of analyzing, diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of Dr. Roadhouse. I understand that analysis, diagnosis or treatment of me by Dr. Roadhouse may be conditioned upon my consent as evidenced by my signature below.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Dr. Roadhouse is not required to agree to the restrictions that I may request. However, if Dr. Roadhouse agrees to a restriction that I request, the restriction is binding on Dr. Roadhouse.

My "protected health information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

This authorization shall be in force and effect until 2 years from initial date of service, at which time this authorization to use or disclose this protected health information expires.

Dr. Roadhouse will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights) and/or to refuse to sign this authorization. I understand that the use or disclosure requested under this authorization may result in direct or indirect remuneration to Dr. Roadhouse from a third party.

I have been provided with a copy of the Notice of Privacy Practices of Dr. Roadhouse and understand that I have a right that notices Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Dr. Roadhouse. The Notice of Privacy Practices for Dr. Roadhouse is also posted in the waiting room at 6565 S. Yale Avenue, Suite 901, Tulsa, Oklahoma 74136. This Notice of Privacy Practices also describes my rights and duties of Dr. Roadhouse with respect to my protected health information.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Nelda Driggs, the Privacy Officer of Dr. Brian Roadhouse, at 6565 S. Yale Ave, Suite 106, Tulsa, Oklahoma 74136. I understand that a revocation is no effective to the extent that Dr. Roadhouse has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state law.

Dr. Roadhouse reserves the right to change the practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling th office of Dr. Roadhouse and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

I,____hereby authorize Dr. Roadhouse to use the

following protected health information, and/or disclose the following protected health information to the following entity(s):

Another healthcare provider, A health plan, My employer, My attorney, A healthcare clearinghouse, My accountant/secretary/other

(named):____

This protected health information is being used or disclosed for the following purposes: Treatment, Payment, Operations & Emergencies.

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Signature of Patient or Personal Representative

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Printed Name of Patient

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Date of Signing

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Description of Personal Representative's Authority