Lynn E. Frame, M.D.
Daran L. Parham, M.D

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

I understand that as part of my healthcare, Utica Women's Specialists, LLC, Lynn E. Frame, M.D., Inc., and Daran L. Parham, M.D., LLC, (hereinafter collectively referred to as "UWS") originate and maintain health records describing my health history, symptoms, examinations, test results, diagnoses, treatment, and any plans for future care or treatment. 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 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 ***notice*** prior to signing this consent. I understand that UWS reserves the right to change its notice and practices. UWS will provide each patient with a copy of the revision of its notice and practices at the time of the patient's next visit or mail a copy to the patient at her last known address if there is a need to use or disclose any protected health information of the patient. 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 UWS 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.

I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE SAID INFORMATION REQUESTED BY INSURANCE COMPANIES WITH WHOM I HAVE COVERAGE OR ANY PUBLIC AGENTS SOLELY TO DETERMINE BENEFITS FOR SERVICES PROVIDED. RELEASE OF INFORMATION FOR ANY OTHER PURPOSE WILL REQUIRE WRITTEN CONSENT OF PATIENT OR LEGAL REPRESENTATIVE.

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 non-communicable disease.

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

_____

Please indicate below (by name and relationship), the persons to whom we may release your 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:_____

_____ _____

Signature of Patient or Legal Representative **Date Notice Effective**

Lynn E. Frame, M.D./Daran L. Parham, M.D. ☐ accepts ☐ denies ☐ accepts conditionally, the restrictions imposed on the release of information as stated above.

_____ _____

Signature *Date*