Stillwater Cancer Center

A DIVISION OF STILLWATER MEDICAL
PARTNERING WITH OKLAHOMA CANCER
SPECIALISTS AND RESEARCH INSTITUTE

1201 W. 6th AVE. STILLWATER, OK 74074
PHONE: (405) 742-4930 FAX: (405) 742-4917

Consent to the Use and Disclosure of Health Information For Treatment, Payment, or Healthcare Operations

I understand that as part of my health and medical care, The Cancer Center, A division of Stillwater Medical Center, originates and maintains medical and health records describing my health history, symptoms, examination and test results, diagnosis, 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.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of health care 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 PATIENT PRIVACY NOTICE prior to signing this consent. I understand that The Cancer Center, A division of Stillwater Medical Center, 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, but not limited to, records involving diseases such as hepatitis, syphilis, gonorrhea, and the Human Immunodeficiency Virus (HIV), also known as Acquired Immune Deficiency Syndrome (AIDS).

I hereby give my permission for any employee of The Cancer Center, A division of Stillwater Medical Center, to leave messages regarding my care or appointments with family members or on my answering device.

PATIENT SIGNATURE: _____ DATE: _____