Dr.Nesbit, PLLC
3315 E 47th Place, Suite 120
Tulsa, OK 74135

Health Information Portability and Accountability Act

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- I understand that by use of email or text to contact Dr. Nesbit or his staff, that I do so willingly. Email or text outside of Athena is not HIPAA secure and this information should not be considered private. I release Dr. Nesbit, PLLC from any liability from data sent via text or email should it be compromised.

May we phone, email, or send a text to you to confirm appointments?	Yes	No
May we phone, email, or send a text to you to confirm appointments?	Yes	No
May we discuss your medical condition with any member of your family?	Yes	No

If YES, please name the members allowed:

_____

_____

Patient Name: _____

This consent was signed by: _____
(Please print name and relation if not patient)

Signature: _____ Date: _____

Witness: _____ Date: _____

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Consent for Authorization to View Other Clinic Electronic Medical Records

Health Information Exchange (HIE) is a way for health care providers, hospitals, laboratories, and organizations involved in your care coordination and payment to see your electronic health records to improve the quality of health care services. By signing this form, you acknowledge that healthcare organizations where you have received or may receive care in the future, will have the ability to access your health information electronically. Your information is shared via a secure network and may be stored in a secure system to ensure the safest and most efficient exchange of your information. This network allows authorized health care providers/organizations and professionals involved in your treatment, coordination of care, quality improvement and activities related to management or payment of your healthcare access to your health records quickly to provide you with the appropriate medical treatment and related services.

HEALTH INFORMATION TO BE DISCLOSED

The electronic disclosure of information includes all types of information, including sensitive health conditions, from your medical records to your health care provider, designated staff and approved HIE participants. This includes, but is not limited to, information about:

- Treatment
- Medication(s)
- Allergies
- Diagnosis, including HIV
- Procedure
- laboratory and other test results such as HIV tests
- mental health, developmental disabilities, alcoholism, drug dependence or substance

USE AND REDISCLOSURE OF INFORMATION

The electronic release of all of your health information will remain in effect from the date of your signature below and applies to information in existence as of this date and any additional health information that may come into existence during the subsequent agreement. The health care organization(s) and HIEs will use this information for the purpose of continuity of your care and it will maintain the information according to its own policies and practices. It may re-disclose some or all of that information as permitted by state and federal laws and regulations.

YOUR RIGHTS REGARDING THIS AUTHORIZATION

Signing this form is voluntary, and you may refuse to sign it. No organization may condition treatment, payment, enrollment, or eligibility for benefits based on whether you sign this form. You may request a copy of this form. You also have the right to inspect and receive a copy of your health information disclosed by making a request with the Health Information Management department of the hospital or the office staff at your doctor's office. Please also note that federal law protects your health information from being improperly disclosed

Signature of Patient and/or Guarantor: _____

Relationship to Patient: _____

Date: _____

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Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history. Our vendor is SureScripts.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also, over−the−counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from, my pharmacy, my health plans, and my other healthcare providers.

By signing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression.

_____
Signature of Patient or Legal Guardian

Patient Name: _____

Date: _____