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| ou-logo | **The University of Oklahoma** |  |

**CONSENT FOR USE OF PROTECTED HEALTH INFORMATION FOR**

**IN-OFFICE TREATMENT, PAYMENT, AND OPERATIONS**

I consent to the use of my Protected Health Information for treatment, payment for treatment, and OU’s health care operations purposes for myself or for the patient for whom I am the parent or legally authorized representative. I understand that the University of Oklahoma (“OU”) will share patient protected health information according to the federal and state law for treatment, payment, and operations, as well as in accordance with its Notice of Privacy Practices.

I understand that the patient is responsible for all charges incurred, regardless of the patient’s insurance status. I agree that the patient must pay for services as the patient incurs the charges. I authorize OU to provide necessary information to the patient’s insurance carrier or other payer for payment purposes, and I authorize my insurance company/payer to pay OU for services filed on my behalf. This assignment remains effective until I revoke it in writing.

If I am an OU student seeking student health services or treatment, I consent to the release of my treatment/education records for payment for services rendered to my insurance carrier or payer and authorize the carrier or payer to pay OU for services rendered.

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| **Signature of Patient, Parent, or Authorized Legal Representative\*** | |  | **Date** | |  | | **Patient’s Date of Birth** | |
|  |  | | |  | |  | |
| **Print Name of Patient, Parent, or Authorized Legal Representative\*** | |  | **Relationship to Patient** | |  | |

\*May be requested to show proof of representative status