utica park clinic

Patient Information	Legal Name Last First Middle	Nickname

Social Security Number	Birth Date	☐ Male ☐ Female	Marital Status

Street Address	Zip	City	State

Primary Phone ☐ Able to receive text messages	☐ Home ☐ Mobile ☐ Other	Preferred Contact Method ☐ Text ☐ Phone ☐ Email ☐ Other

Email *Required	Occupation	Employer

Primary Care Provider	Referring Provider

As part of the American Recovery and Reinvestment Act, healthcare providers are required to obtain the following information. Please check the boxes in section 1-3 that most apply to you.

1. Race (Choose One)

☐ American Indian or Alaska Native
☐ Native Hawaiian or Other Pacific Islander
☐ More than one race
☐ Asian
☐ White / Caucasian
☐ Unknown / Not Reported
☐ Black or African American
☐ Other _____

2. Ethnicity (Choose One)

☐ Hispanic / Latino
☐ Non-Hispanic / Latino
☐ Unknown / Not Reported

3. Preferred Language (Choose One)

☐ Arabic	☐ French	☐ Hindi	☐ Khmer	☐ Russian	☐ Thai
☐ Bulgarian	☐ German	☐ Hmong	☐ Korean	☐ Spanish	☐ Urdu
☐ Chinese	☐ Haitian	☐ Italian	☐ Polish	☐ Somali	☐ Vietnamese
☐ English	☐ Hebrew	☐ Japanese	☐ Portuguese	☐ Swahili	☐ Other

Responsible Party (Policy Holder) / Legal Guardian *if minor, please have parent or legal guardian complete the following.*

☐ Self

Legal Name Last First Middle	Relationship to Patient	Birth Date

Social Security Number	Address	☐ Check here if same address as above

Primary Phone ☐ Able to receive text messages	☐ Home ☐ Mobile ☐ Other	Employer

Emergency Contact	Name Last First Middle	Relationship to Patient

Address

Primary Phone ☐ Able to receive text messages	☐ Home ☐ Mobile ☐ Other	Employer

utica park clinic

Patient _____ DOB _____

Insurance

Primary Insurance Name	Policy Holder's Name	Relationship to Patient	Policy Holder's Birth Date
Secondary Insurance Name	Policy Holder's Name	Relationship to Patient	Policy Holder's Birth Date

Medications *include over-the-counter medications and supplements.* ☐ *check box if NO medications.*

Drug Name	Dosage Strength (i.e., mg/mcg)	How many times a day?
1		
2		
3		
4		
5		
Attach additional list if there are more medications		

Allergies ☐ *check box if there are NO medication allergies.*

Drug Name / Drug Class / Food	Reaction
1	
2	
3	
4	

Preferred Local Pharmacy

Name _____ Location _____

Phone _____ Fax _____

Medical History *check all that apply. Describe details of medical conditions in spaces below.*

☐ allergies	☐ cancer: type _____	☐ high blood pressure	☐ migraines
☐ anemia	☐ COPD (Emphysema)	☐ high cholesterol	☐ osteoporosis
☐ angina (heart pain)	☐ Crohn's Disease	☐ HIV / AIDS	☐ prostate enlarged
☐ anxiety	☐ depression	☐ irritable bowel syndrome	☐ seizures
☐ arthritis	☐ diabetes ☐ type 1 ☐ type 2	☐ kidney disease: type _____	☐ stroke
☐ asthma	☐ GERD (acid reflux)	☐ liver disease: type _____	☐ thyroid disease: type _____
☐ atrial fibrillation	☐ heart disease: type _____	☐ MI (heart attack)	☐ ulcer
☐ blood clots	☐ Hepatitis ☐ A ☐ B ☐ C		
☐ Other:			

utica park clinic

Patient _____ DOB _____

Surgeries *check all that apply. Describe details of surgery in spaces below.*

- ☐ angioplasty
- ☐ appendectomy
- ☐ arthroscopy knee: ☐ left ☐ right
- ☐ back surgery: type _____
- ☐ breast biopsy: ☐ left ☐ right
- ☐ breast implants
- ☐ breast reduction
- ☐ CABG (heart vessel bypass)
- ☐ cardiac pacemaker
- ☐ carpal tunnel: ☐ left ☐ right
- ☐ cataract: ☐ left ☐ right
- ☐ colon surgery: type _____
- ☐ c-section
- ☐ D&C
- ☐ gallbladder
- ☐ gastric bypass
- ☐ groin hernia repair: ☐ left ☐ right
- ☐ hip fracture repair: ☐ left ☐ right
- ☐ hip replacement: ☐ left ☐ right
- ☐ hysterectomy
- ☐ knee replacement: ☐ left ☐ right
- ☐ LASIK
- ☐ liver biopsy
- ☐ mastectomy: ☐ left ☐ right
- ☐ ovary removed: ☐ left ☐ right
- ☐ prostate surgery: type _____
- ☐ thyroid surgery
- ☐ tonsillectomy
- ☐ tubes tied
- ☐ vasectomy

**items in gray are for females only*

☐ Other:

Family History

Mother
☐ ADD/ADHD ☐ alcoholism ☐ allergies ☐ Alzheimer's ☐ asthma ☐ bleeding disorder
☐ cancer: type: _____ ☐ depression ☐ diabetes ☐ type 1 ☐ type 2 ☐ heart attack
☐ heart disease ☐ high blood pressure ☐ high cholesterol ☐ mental illness ☐ migraines
☐ osteoporosis ☐ seizure ☐ stroke ☐ thyroid disease ☐ tuberculosis
☐ ulcerative colitis ☐ other: _____

Father
☐ ADD/ADHD ☐ alcoholism ☐ allergies ☐ Alzheimer's ☐ asthma ☐ bleeding disorder
☐ cancer: type: _____ ☐ depression ☐ diabetes ☐ type 1 ☐ type 2 ☐ heart attack
☐ heart disease ☐ high blood pressure ☐ high cholesterol ☐ mental illness ☐ migraines
☐ osteoporosis ☐ seizure ☐ stroke ☐ thyroid disease ☐ tuberculosis
☐ ulcerative colitis ☐ other: _____

Brother(s)
☐ ADD/ADHD ☐ alcoholism ☐ allergies ☐ Alzheimer's ☐ asthma ☐ bleeding disorder
☐ cancer: type: _____ ☐ depression ☐ diabetes ☐ type 1 ☐ type 2 ☐ heart attack
☐ heart disease ☐ high blood pressure ☐ high cholesterol ☐ mental illness ☐ migraines
☐ osteoporosis ☐ seizure ☐ stroke ☐ thyroid disease ☐ tuberculosis
☐ ulcerative colitis ☐ other: _____

Sister(s)
☐ ADD/ADHD ☐ alcoholism ☐ allergies ☐ Alzheimer's ☐ asthma ☐ bleeding disorder
☐ cancer: type: _____ ☐ depression ☐ diabetes ☐ type 1 ☐ type 2 ☐ heart attack
☐ heart disease ☐ high blood pressure ☐ high cholesterol ☐ mental illness ☐ migraines
☐ osteoporosis ☐ seizure ☐ stroke ☐ thyroid disease ☐ tuberculosis
☐ ulcerative colitis ☐ other: _____

Social History *your answers help determine your risk for certain diseases. Responses are confidential.*

☐ Married ☐ Domestic Partnership
☐ Single ☐ Divorced ☐ Widowed

Sexual Orientation:
☐ Bisexual ☐ Heterosexual ☐ Homosexual

Transgender Identity
☐ Female to Male ☐ Male to Female ☐ Unknown

Do you have any religious or spiritual preferences that would affect your healthcare?

Tobacco Use

Do you... ☐ smoke a pipe
☐ chew tobacco
☐ smoke cigarettes

How many... packs per day? _____
years? _____

If you quit, what year? _____

Do you drink *alcohol?* ☐ Yes ☐ No
If yes, what type? _____
If yes, how much? _____
If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

Do you use *illegal drugs?* ☐ Yes ☐ No
If yes, what type? _____
If yes, how much? _____
If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Rarely

utica park clinic

Patient _____ DOB _____

Women's Health History

Age of first menstrual period? _____ Are you currently pregnant? ☐ Yes ☐ No ☐ Possibly

Age of first birth? _____ Date of last mammogram? _____ Result? _____

Beginning date of last menstrual period? _____ Date of last pap smear? _____ Result? _____

If you have achieved menopause, what age? _____ What Year? _____ ☐ Natural ☐ Surgical *(choose one)*

Pregnancy History *list the number of each type in the box below.*

Full Term	Premature	C-Section	Vaginal	Live Birth	Ectopic	Miscarriage	Abortion

Preventive Screenings *list dates of the most recent preventive services you've received.*

Test	Test Never Performed	Where Performed?	Last Exam Date	Findings/Results
Bone density	☐			
Blood sugar	☐			
Cholesterol	☐			
Colonoscopy	☐			
Glaucoma	☐			
Hearing	☐			
HIV	☐			
Lung cancer scan (CT of chest)	☐			
Lung scan	☐			
Mammogram	☐			
Medicare wellness visit	☐			
Prostate exam (males only)	☐			
Ultrasound aorta	☐			
Vision	☐			
Vision examination	☐			

Immunizations *list dates of most recent immunizations or attach record.*

Vaccination	Date	Date	Date
Chicken Pox			
Hepatitis A			
Hepatitis B			
HPV			
Influenza			
Meningococcal			
MMR			
Pneumonia PCV13 (Prevnar 13)			
Pneumonia PPSV23 (Pneumovax)			
Shingles			
Tetanus and Diphtheria (Td)			
Tetanus, Diphtheria, Pertussis (Tdap)			

REVIEW OF SYSTEMS

Dr. Laurie Flynn

Please circle if you CURRENTLY have any of the following symptoms: NONE

Constitutional
Change in Appetite
Fever
Weight Gain
Weight Loss

HEENT
Headache
Visual Loss
Hearing Loss
Vertigo
Nasal Congestion

Respiratory
Cough
Shortness of Breath
Painful Respirations

Cardiovascular
Chest Pain (Cardiac)
Edema (Swelling)
Irregular Heartbeat

Vascular
Ulcer
Varicose Veins

Gastrointestinal
Abdominal Pain
Blood in Stool
Constipation
Vomiting
Nausea

Genitourinary
Back Pain
Dysuria
Hematuria
Urinary Incontinence

Reproductive
Menarche Age_____
Premenopausal
Perimenopausal
Postmenopausal
Age_____
Year_____
Hormone Replacement
Breast Discharge
Breast Lumps
Breast Pain

Breast Self Exam Yes or No
Last Mammogram_____
Last PAP Smear_____

Oral Contraception
Non Oral Contraception
Name_____

Metabolic/Endocrine
Chronically Overweight
Chronically Underweight
Heat Intolerance
Tremors

Neuro/Psychiatric
Loss of Consciousness
Seizures

Dermatologic
Hair Loss
Rash
Frequent Skin Infections

Musculoskeletal
Back Pain
Muscle Weakness

Hematologic
Swollen Lymph Nodes
Stroke
Blood Clots

Immunological
Urticaria/Hives
Animals at Home
Asthma

utica park clinic

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME: _____

DATE OF BIRTH:_____ Medical record #_____

I hereby authorize the use or disclosure of the Protected Health Information described below to be provided to or obtained by the following:

Name and Address of Individual/Facility/Company to Receive PHI	Name and Address of Individual/Facility to Disclose PHI
_____	_____
_____	_____
_____	_____

Information authorized for use or disclosure, or to be obtained:

☐Immunization Records ☐TB Skin Test Results ☐Lab reports ☐X-ray Reports ☐Progress Notes ☐History & Physical

☐Discharge Summary ☐Operative Report ☐ER Record ☐Consultation ☐Addendum Denial ☐Other_____

☐Medical information between _____ to _____

The information will be obtained, used, or disclosed for the **following purpose** only:

☐Insurance ☐Continued treatment ☐Legal ☐At the request of the patient or patient's representative

☐Other (specify) _____

I understand:

- I may revoke this authorization at any time, in writing, except revocation will not apply to information already retained, used or disclosed in response to this authorization. I may revoke this document by presenting my written revocation as provided in the Notice of Privacy Rights. Unless revoked, the automatic expiration date will be six (6) months from date of signature or upon occurrence of the following event:_____.
- I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information. The entity authorized to disclose the information will not be compensated by the recipient for such disclosure. Normal applicable fees, such as copy fees, may apply.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment, payment, enrollment in a health plan, or eligibility for benefits on obtaining this authorization.

I understand that the information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease and may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency viruses also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____
SIGNATURE OF PATIENT DATE

_____ _____
SIGNATURE OF PERSONAL REPRESENTATIVE DATE

_____
DESCRIPTION OF REPRESENTATIVES AUTHORITY TO ACT FOR THE PATIENT

NOTICE OF RIGHTS: Information in your medical records that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law

Processed by (Print Name & Dept):_____

utica park clinic

MEDICAL AND FINANCIAL CONSENT

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

MEDICAL TREATMENT AUTHORIZATION

I agree to procedures that are requested by me and/or ordered by my physician(s) in connection with my inpatient, outpatient and/or emergency treatment, and medications. If I am a pregnant patient, I consent to hospital care of my infant(s) and consent for release of my private health information needed to care for my infant. You have the right to accept or refuse any care, treatment or service your physician or staff recommends to you. You should ask for information about anything you do not understand or if you need more information.

I acknowledge that I have received written notice of my patient rights, including my right to execute an Advance Directive in accordance with Oklahoma State Law.

☐ Yes ☐ No I have a legal representative

☐ Yes ☐ No I want to appoint a patient representative to make decisions for me should I become unable to make healthcare decisions. If yes, the following person should make decisions for me: _____ and their contact information is: _____.

☐ Yes ☐ No Do you wish the clinic to notify your patient representative or legal representative of your appointment?

I understand I have a right to receive information in a manner or language I, and/or my representative, can understand. I understand interpreter services are available 24 hours a day at no cost.

If my treatment includes treatment groups, I understand that my participation in these groups or classes may involve discussions of my condition in the presence of other patients and I consent to the discussion.

I understand that the practice of health care delivery may involve “telemedicine” which is the transfer of my medical data, or exchange of medical information by means of audio, video or data communication to a medical care provider with expertise in a particular area of care. A healthcare provider may be able to assist in the examination and provide additional information about a diagnosis. The physician and staff who have access to your medical information will keep it confidential in accordance with laws and confidentiality policies.

NOTICE OF PRIVACY PRACTICES

Protected health information may be used and disclosed ot carry out treatment, payment or healthcare operations. Please refer to the Notice of Privacy Practices for complete description of uses and disclosures. I acknowledge that I have received a written Notice of Privacy Practices.

By signing below, I acknowledge that I have received a copy of the Utica Park Clinic Notice of Privacy Practices and that I agree to uses and disclosures described in the Notice of Privacy Practices listed under the section: How We May Use and Disclose Your Health Information.

_____ _____

☐ Patient Signature ☐ Patient Personal Representative Date/Time

TELEPHONE CONSUMER PROTECTION ACT CONSENT DISCLOSURE

I expressly consent to allow Utica Park Clinic (UPC), to contact me by use of an automated telephone dialing device and to leave automated or pre-recorded voice messages, send me text messages, short message services messages (SMS), or send me email messages regarding my treatment, notification of appointments, notification that certain medications or other products or services being provided are ready for pick-up, communicate to me about my account, or communicate with me regarding the collection of any money that I may owe to UPC related to treatment provided to me, my child, or person to whom I am guardian. I agree that this prior express written consent shall also extend to any third party that is servicing my account on behalf of UPC or attempting to collect any money due regarding my account on behalf of UPC. This consent does not extend to telemarketing of future goods and services to me. My express consent includes contact to the following telephone numbers and email addresses.

Residential Land Line Telephone Number: _____ Cellular or Wireless Telephone Number: _____

Other Telephone Number: _____ Email Address: _____

FINANCIAL RESPONSIBILITY

I hereby assign to Utica Park Clinic (UPC) and any health care provider designated by UPC to receive such monies, and all rights and interest in insurance benefits and/or entitlements and I direct that all such payments be made directly to UPC or its designee. Charges for services shall be at the provider’s regular rates unless otherwise agreed in writing by UPC or as required by law.

I understand I am financially responsible for deductibles, coinsurance, and all services not covered by insurance benefits and/or entitlements. A safe is available for safekeeping of valuables. UPC and its affiliates are released from responsibility for all valuables or personal items, including eyeglasses, dentures, and hearing aid(s) and jewelry that I retain in my possession during my clinic visit.

_____ _____ _____

☐ Patient ☐ Guardian ☐ Parent of Minor Witness Date/Time

If not signed, complete the following to explain the reason why:

☐ Emergency situation ☐ Individual refused to sign ☐ Unable to sign Reason _____

utica park clinic

MEDICAL AND FINANCIAL CONSENT

INFORMATION ABOUT YOUR SPECIFIC RIGHTS ABOUT ADVANCE DIRECTIVES

The Patient Self Determination Act directs Utica Park Clinic to inform you that you have rights under Oklahoma State Laws to make decisions about your care. You have the right to accept or refuse any procedure or care that your physician or staff recommends to you. Your physician will prescribe a treatment plan for you and talk with you about those recommendations including the risks, benefits and alternatives. You should ask for information about anything you do not understand or if you need more information. If at any time you feel your rights are not being respected, your nurse will help you contact the hospital representative.

The Oklahoma Rights of the Terminally Ill and Persistently Unconscious Act (Living Will/Appointment of a Healthcare Proxy Law) is a way for a person with decision making capacity to specify future circumstances and conditions in which life sustaining treatment should be withheld. You can appoint another person (aka: surrogate decision maker) to make those decisions for you should you become unable to make decisions for yourself. You can do both. A Living Will does not address your wishes or belongings after death. It is only for certain types of healthcare decisions. A Living Will may apply only to future events or circumstances when the person becomes terminally ill, not necessarily the present. The Oklahoma Do Not Resuscitate Act provides a specific written form called a DNR form that you should sign **only** if you are certain that under no circumstances is cardiopulmonary resuscitation to be provided. A copy of each of these types of Advance Directives can be made available to you and our staff may assist you if you elect to complete an advance directive. If you are scheduled for surgery you will want to talk with your surgeon and your anesthesiologist about your advance directive prior to surgery. We will not recognize DNR during anesthesia. If considering such documents raises difficult issues for you, our Pastoral Care Department is available for more intensive help. You may also have a Durable Power of Attorney for Healthcare. Utica Park Clinic recommends that all individuals appoint a healthcare proxy to assure that someone the individual knows/trusts is authorized to make decisions for them if they become incapacitated.

A psychiatric advance directive is akin to a traditional advance directive for healthcare. An individual who is concerned that at some point he/she may be subject to involuntary psychiatric commitment or treatment has the right to execute a psychiatric advance directive. The psychiatric advance directive names another person who is authorized to make decisions for the individual if he/she is determined to be legally incompetent to make his/her own choices. It may include instructions about hospitalization, alternatives to hospitalization, the use of medications, types of therapies and the patient's wishes concerning restraint or seclusion. It includes information as to who to notify upon appointment, as well as who should not be permitted to visit.

You should keep your advance directive at home with you in a safe place. You should provide a copy to your primary care physician for your medical record in their office. Tell your family where your advance directive is. We recommend that you talk with them about it. **Do not put your advance directive in a safe deposit box with other important papers.** Your family and healthcare providers need access to it readily when you are unable to make decisions for yourself. We will put a copy in your medical record for this hospitalization.

If you have an advance directive and did not bring it with you, it is urgent that you make arrangements to bring it. In the meantime, our best advice is to complete a document approved by the State of Oklahoma today. Our staff can help you update your current advance directive, or complete a new one. Please tell your doctor and/or nurse about the substance of your advance directive so we can document what you tell us in your medical record. We want to honor your values and wishes about healthcare that you believe is right for you.

COMPLAINTS AND GRIEVANCES

You and/or your representative have the right to express complaints or grievances related to the quality of care received, to have those complaints heard and when possible, resolved. Complaints/grievances should be directed initially to and reviewed by the department and clinical manager and/or director providing the patient care which is the subject of the complaint. If the problem cannot be resolved quickly, it may become a formal grievance handled through the process defined for the clinic.

Patients have the right to address their concerns to Utica Park Clinic Risk Management, 1145 S Utica Ave, Suite 110, Tulsa, OK 74104. 918-579-1073.

Oklahoma State Dept of Health
1000 NE 10th Street
Oklahoma City, OK 73117-1299
www.ok.gov/health
405-271-6576

KEPRO BFCC QIO (Area 3)
Rock Run Center
5700 Lombardo Center Drive, Suite 100 Seven
Hills, OH 44131
Phone: 216-447-9604
Fax: 844-878-7921
www.keproqio.com

utica park clinic

VERBAL DISCLOSURE OF PROTECTED HEALTH INFORMATION TO INDIVIDUALS INVOLVED IN PATIENT CARE

PATIENT NAME: _____ PASSCODE (Optional): _____

DATE OF BIRTH: _____ MRN: _____

In accordance with the provisions of Section 164.510(b) of the Health Insurance Portability and Accountability Act (HIPAA), I agree that Utica Park Clinic and its duly authorized agents and employees may disclose Protected Health Information directly relevant to involvement with my care, or payment related to my care, to my family members, other relatives, close personal friends and/or any other individuals that I indicate below who may contact Utica Park Clinic on my behalf.

NAME OF INDIVIDUAL(S) AND RELATIONSHIP: (Please print)
Check the box next to the name to identify the type of information to be disclosed

☐ Medical ☐ Billing _____

☐ Medical ☐ Billing _____

☐ Medical ☐ Billing _____

I understand:

- At any time, I may add or remove individuals from this list by notifying Utica Park Clinic of my desire to do so. I understand that until I notify Utica Park Clinic of requested changes to this list, Utica Park Clinic may rely on this list and disclose information to the individuals listed above.
- I understand that, on an annual basis, UPC will request an updated form be completed. By updating this form all previous verbal disclosure forms signed by me will be revoked.
- Information disclosed to the individuals identified above may be subject to redisclosure by the recipient and no longer protected by federal law.
- FOR MEDICAL—The permission granted in this form is valid until revoked.
- FOR BILLING—The permission granted is valid until I have notified the facility to change the list and is valid until revoked.

I understand that the information authorized for use or disclosure may include information which may indicate the presence of a communicable or non-communicable disease and may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea, and human immunodeficiency viruses also known as Acquired Immune Deficiency Syndrome (AIDS). I further understand that my medical information may indicate that I have or have been treated for psychological or psychiatric conditions or substance abuse.

_____ _____
SIGNATURE OF PATIENT DATE

_____ _____
SIGNATURE OF PERSONAL REPRESENTATIVE DATE

_____
DESCRIPTION OF REPRESENTATIVES AUTHORITY TO ACT FOR THE PATIENT

NOTICE OF RIGHTS: Information in your medical records that you have or may have a communicable or venereal disease is made confidential by law and cannot be disclosed without your permission except in limited circumstances including disclosure to persons who have had risk exposures, disclosure pursuant to an order of the court or the Department of Health, disclosure among healthcare providers or for statistical or epidemiological purposes. When such information is disclosed, it cannot contain information from which you could be identified unless disclosure of that identifying information is authorized by you, by an order of the court or the Department of Health or by law.

REVOCATION OF VERBAL DISCLOSURE

I may revoke this permission at any time, in writing, except revocation will not apply to information already disclosed in response to this permission.

_____ _____
Patient/Patient Representative Signature Date Signed/Revocation

Staple

utica park clinic
Get Healthy. Stay Healthy.

Effective as of April 1st, 2015

UTICA PARK CLINIC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Utica Park Clinic (UPC) Privacy Officer at 918-579-1073.

This Notice Describes Our Practices And Those Of:

- Any medical staff member and any health care professional who participates in your care;
- Any volunteer we allow to help you while you are here; and
- All employees of any hospital, clinic, laboratory, or other facility affiliated with Utica Park Clinic.

All of these people follow the terms of this notice. They may also share health information that identifies you (also known as "protected health information") with each other for treatment, payment or health care operations as described in this notice.

Our Pledge Regarding Health Information:

We understand that health information about you and your health is personal. We are committed to protecting health information about you. This notice will tell you about the ways that we may use and disclose health information about you. This notice also describes your rights and certain obligations we have regarding the use and disclosure of protected health information. We are required to comply with any state laws that offer a patient/plan member additional privacy protections.

We Are Required By Law To:

- Maintain the privacy of health information that identifies you;
- Give you and other individuals this notice of our legal duties and privacy practices with respect to protected health information;
- Follow the terms of the notice that is currently in effect; and

- **Required By Law.** We may use and disclose information about you as required by law. For example, we may disclose information to report gunshot wounds, suspected abuse or neglect, or similar injuries and events.

- **Public Health.** Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities (*e.g.,* state health department, Center for Disease Control, *etc.*) to prevent or control disease, injury, or disability, or for other public health activities.

- **Law Enforcement Purposes.** Subject to certain restrictions, we may disclose information needed or requested by law enforcement officials.
- **Judicial And Administrative Proceedings.** We may disclose information in response to an appropriate subpoena, discovery request or court order.
- **Health Oversight Activities.** We may disclose your health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections to monitor the health care system.
- **Decedents.** Health information may be disclosed to funeral directors, medical examiners or coroners to enable them to carry out their lawful duties.
- **Organ/Tissue Donation.** Your health information may be used or disclosed for cadaveric organ, eye or tissue donation purposes.
- **Research.** We may use or disclose your health information for research purposes after a receipt of authorization from you or when an institutional review board (IRB) or privacy board has waived the authorization requirement by its review of the research proposal and has established protocols to ensure the privacy of your health information. We may also review your health information to assist in the preparation of a research study.
- **Health And Safety.** Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.
- **Government Functions.** Your health information may be disclosed for specialized government functions such as protection of public officials or reporting to various branches of the armed services.
- **Workers' Compensation.** Your health information may be used or disclosed in order to comply with laws and regulations related to Workers' Compensation.
- **Business Associates.** We may disclose your health information to business associates (individuals or entities that perform functions on our behalf) provided they agree to safeguard the information.
- **Other Uses And Disclosures.** We may contact you to provide appointment reminders or for billing or collections and may leave messages on your answering machine, voice mail or through other methods. Except for uses and disclosures described above, we will only use and disclose your health information with your written authorization. Subject to compliance with limited exceptions, we will not use or disclose psychotherapy notes, use or disclose your health information for marketing purposes or sell your health information, unless you have signed an authorization. You may revoke an authorization by notifying us in writing, except to the extent we have taken action in reliance on the authorization.

utica park clinic
Get Healthy. Stay Healthy.

Effective as of April 1st, 2015

Your Health Information Rights:

You have the right to:

- Obtain a paper copy of this notice of information practices upon request, even if you have previously agreed to receive this notice electronically;
- Inspect and obtain a copy of your health information that we maintained;
- Request an amendment to your health information under certain circumstances;
- Request a confidential communication of your health information by alternative means or at alternative locations. Please be advised that this request for alternative means or locations of communications applies only to this provider or location;
- Receive an accounting of certain disclosures made of your health information; and
- Request a restriction on certain uses and disclosures of your information. We are not required to agree to a requested restriction, except for requests to limit disclosures to your health plan for purposes of payment or health care operations when you have paid for the item or service covered by the request out-of-pocket and in full and when the uses or disclosures are not required by law.

To exercise any of these rights, please contact our Privacy Officer at the address at the end of this notice.

Changes To This Notice:

We reserve the right to change the terms of this notice and make the new terms effective for all protected health information kept by *UPC.* We will post a copy of the current notice in our facility and on our website, http://www.uticaparkclinic.com. You may also get a current copy by contacting our Privacy Officer at the address at end of this notice. The effective date of the notice is in the top right-hand corner of each page.

Complaints:

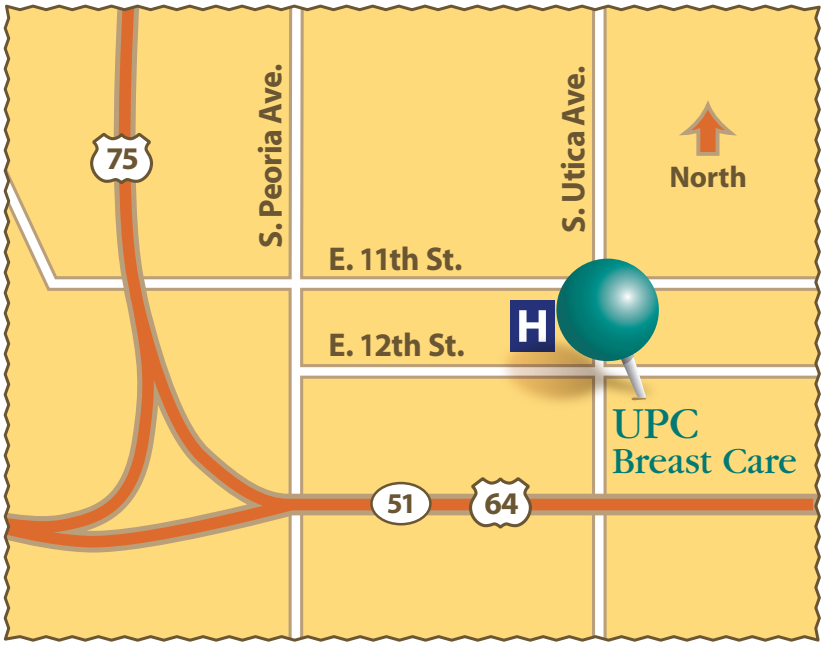
If you believe your privacy rights have been violated, you may file a complaint with UPC or with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with *UPC*, submit your written complaint to our Privacy Officer at the address at end of this notice. You will not be penalized for filing a complaint.

Contact Information For Questions Or To File A Complaint:

If you have any questions about this notice, want to exercise one of your rights that are described in this notice, or want to file a complaint, please contact the UPC Privacy Officer at:

Utica Park Clinic
1145 S. Utica Avenue, Suite 110
Tulsa, OK 74104
Attn: Privacy Officer
Phone: 918-579-1073

utica park clinic
Breast Care



Utica Park Clinic
Breast Care
1245 S. Utica, Suite 103
Tulsa, OK 74104
918.579.3840
UticaParkClinic.com

Laurie Flynn, MD, FACS

Brandi Baxter, APRN-CNP

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