

ADA OUTPATIENT CLINIC  
2901 ARLINGTON  
ADA, OK 74820

File in patient chart  
HIPAA document

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT AND CONSENT**

The Notice of Privacy Practices tells you how we may use and share your health records. Please read the following.

- \*We will use share your health records to provide medical treatment to you.*
- \*We will use share your health records to bill for the services we provide.*
- \*We will use share your health records to run our business.*
- \*We will use share your health records as required by law.*

All the ways we use and share your health records are explained in more detail in the Notice of Privacy Practices. If you would like a full length copy of the Notice of Privacy Practices please ask for one.

- \*You have the right to look at and receive a copy of your health records.*
- \*You have the right to ask for us to correct a mistake in your health records.*
- \*You have the right to ask for a list of disclosures of your health records.*
- \*You have the right to ask that we not use or share your health records.*
- \*You have the right to ask us to change the way we contact you.*

All of these rights are explained in more detail in the Notice of Privacy Practices.

I have received a copy of Ada Outpatients Clinic's Notice of Privacy Practices:

**NAME (print):** \_\_\_\_\_

**✕ Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Of Patient or Legal Representative)

Capacity (role) of Legal Representative (if applicable)\*: \_\_\_\_\_

The following is a list of names and numbers of individuals which I give consent to receive access to any and all of my medical records. I am aware that I am responsible for contacting this office if anyone needs to be added or deleted from this list at any time.

NAME: CONTACT#: ( )

NAME: CONTACT#: ( )

I consent to the to the use and sharing of my health records for treatment, payment, and operation purposes as described in the Notice of Privacy Practices. I know that if I do not consent, you can not provide services to me.

*Oklahoma law requires that we advise you that the information authorized for disclosure may include information which may be considered a communicable or venereal disease, including, but not limited to hepatitis, Syphilis, Human Immunodeficiency Virus (HIV), and Acquired Immune Deficiency Syndrome (AIDS). It may also include mental health or other sensitive information.*

**✕ Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(Of Patient or Legal Representative)

Capacity (role) of Legal Representative (if applicable)\*: \_\_\_\_\_

**\*May be required to provide verification of representative status.**

**STAFF ONLY: If patient did not, or could not, acknowledge receipt of the notice, indicate why.**