OKLAHOMA OTOLARYNGOLOGY ASSOCIATES, L.L.C.

ACKNOWLEDGEMENT OF RECEIPT AND AUTHORIZATION TO CONSENT SIGNATURE PAGE

OKLAHOMA HEARING CENTER

Patient Name:		Date of Birth:
Patient Social Security#:		
Patient Address:		Phone:

Authorization to Consent: (**Adult Patient**)

I, _____ am giving consent for the below mentioned person/persons to obtain medical care for myself in my absence. I understand I am fully responsible for all medical expenses incurred with said medical treatments.

Authorization to Consent: (Pediatric Patient)

I, _____ am the parent of and/or legal guardian for the above mentioned patient and am giving consent for the below mentioned person/persons to obtain medical care for this patient in my absence. I understand that I am fully responsible for all medical expenses incurred with said medical treatments.

Access to All Medical Records	Financial Records Only	Designated Representative	Relationship to Patient

- **All Medical Records would include making appointments, picking up prescriptions, release of records, etc.**
- By signing, I acknowledge that I have read and received a copy of the Oklahoma Otolaryngology Associate, LLC's and/or Oklahoma Hearing Center's Notice of Privacy Practice/Patient Rights and Responsibilities, as required by **HIPAA**.
- By signing, I acknowledge that I have read and received a copy of the Oklahoma Otolaryngology Associate LLC's and/or Oklahoma Hearing Center's **Financial Policy**.
- By signing, I acknowledge that I have read and received a copy of the Oklahoma Otolaryngology Associate LLC's and/or Oklahoma Hearing Center's **Ownership Disclosure Policy**.
- I understand that if I want to make any changes to the information listed above, I must contact Oklahoma Otolaryngology Associates and/or Oklahoma Hearing Center to revoke this form in its entirety or complete a new form.

_____ _____

Signature of Patient Date Signature of Parent/Legal Guardian Date

_____ _____

Witnessed Date Relationship to Patient

In Case of Emergency, I can be reached at:_____ (Emergency phone)

____ I, _____ do not wish to allow anyone other than myself to have access to my medical records and/or financial records for any reason.