Required by Federal Law. Please read, sign and date by the X at the bottom.

J. David Lackey, M.D., Inc.

Fellow American College of Obstetrics and Gynecology
Certified, American Board of Obstetrics and Gynecology

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CONSENT TO THE USE AND DISCLOSER OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of health and medical care, Dr. Lackey's office originates and maintains medical and health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I further understand that this information serves as:

*a basis for planning my care and treatment
*a means of communication among the health professionals who contribute to my care
*a source of information for applying my diagnosis and treatment information to my bill
*a means for a third-party payer to verify that services were billed and actually provided
*and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I further understand and agree that this agreement to release information shall apply to all information accumulated up to this date and to any information acquired in the future. This agreement to release information shall remain in force until such time as I revoke it in writing.

I understand and have been provided with a PATIENT PRIVACY NOTICE that provides a more complete description of information uses and disclosers. I understand that I have the right to review the PATIENT PRIVACY NOTICE prior to signing this consent. I understand that Dr. Lackey's office has the right to change their notice and practices and a copy of the current PATIENT PRIVACY NOTICE will be posted in the office for review at any time. I understand I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Dr. Lackey is not required to agree to the restrictions requested. I understand that I must revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon.

By Oklahoma law we are required to notify you .... **that the information authorized for release may include records which may indicate the presence of a communicable disease which may include but are not limited to diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (Aids).**

I request the following restrictions to the use and/or disclosure of my health information in addition to those described above:

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____

I request the following people/organizatons be permitted to recieve and use my health information:

____

____

J. David Lackey, M.D. Inc ______accepts______denies______accepts conditionally the restrictions imposed on release of information as stated above.

______________________________ Signature/Title

______________________________ Date

X

______________________________ Signature of Patient or Legal Representative

______________________________ Date Notice Effective