

OU Health Services  
Goddard Health Center  
620 Elm  
Norman, Oklahoma 73019-0340

**ACKNOWLEDGEMENT OF RECEIPT OF  
NOTICE OF PRIVACY PRACTICES**

I acknowledge that I have been provided the University of Oklahoma's ("OU") Notice of Privacy Practices ("Notice").

- It tells me how OU will use my health information for the purpose of my treatment, payment for treatment, and OU's health care operations.
- The Notice also explains in more detail how OU may use and share my health information for other than treatment, payment, and health care operations.
- OU will also use and share my health information as required/permitted by law.

Patient's COMPLETE Legal Name: \_\_\_\_\_  
Please Print Legibly

Patient's SSN: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_

Patient's Sooner ID#: \_\_\_\_\_

SIGNATURE  
of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

SIGNATURE of Legally  
Authorized Guardian  
or Representative if  
Patient is a Minor: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship of Guardian or Representative to Patient: \_\_\_\_\_

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**CONSENT FOR TREATMENT**

The following information is to be completed by the patient, or the patient's legally authorized representative/parent:

I consent to medical treatment 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 health information according to federal and state law for treatment, payment, and operations.

I understand that the patient is responsible for all charges incurred, regardless of the patient's insurance status. The patient agrees to pay for services as the patient incurs the charges. I authorize the insurance provider to pay OU for services rendered.

Patient's COMPLETE Legal Name: \_\_\_\_\_

Patient's SSN: \_\_\_\_\_ Patient's DOB: \_\_\_\_\_

Patient's Sooner ID#: \_\_\_\_\_

SIGNATURE  
of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

SIGNATURE of Legally  
Authorized Guardian  
or Representative if  
Patient is a Minor: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship of Guardian or Representative to Patient: \_\_\_\_\_