



**Central States Orthopedic**  
SPECIALISTS, INC.

**ASSIGNMENT & CONSENT**

Patient Name: \_\_\_\_\_

**Authorization to Pay Benefits to Physician:** I hereby assign payment directly to Central States Orthopedic Specialists, Inc. for the surgical and/or medical benefits, if any, otherwise payable to me for services as described, but not to exceed my indebtedness to said physician and/or surgeon for those services. I understand I am financially responsible for the charges incurred by the patient named above.

\_\_\_\_\_  
Signed (Patient, Parent or Authorized Person)

\_\_\_\_\_  
Date

**Consent for Treatment and Payment:** I hereby give Central States Orthopedic Specialists, Inc. consent to treat me and to release any information required in the course of my examination or treatment to my referring doctor, my insurance company, and/or other treating health care entities or providers. I understand that this release covers multiple requests for such information by my referring doctor, my insurance company, and/or other treating health care entities or providers, and that this release authorizes CSOS to respond to such requests.

Per 63 O.S. § 1-502.2, all requests for release of medical records must contain the following language:

**I understand that my medical records may contain information that indicates that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

\_\_\_\_\_  
Signed (Patient, Parent or Authorized Person)

\_\_\_\_\_  
Date

**Work Comp:** I hereby give Central States Orthopedic Specialists, Inc. consent to release to \_\_\_\_\_, my employer, their insurance carrier or other representative any information regarding my medical condition or treatment.

Per 63 O.S. §1-502.2, all requests for release of medical records must contain the following language:

**I understand that my medical records may contain information that indicates that I have a communicable or venereal disease which may include, but is not limited to, diseases such as hepatitis, syphilis, gonorrhea or the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS).**

\_\_\_\_\_  
Signed (Patient, Parent or Authorized Person)

\_\_\_\_\_  
Date

A photostatic copy of this authorization shall be considered as valid as the original.

***Oklahoma Surgical Hospital***

We are proud to inform you that some of the physicians at Central States Orthopedic Specialists are part owners of Oklahoma Surgical Hospital, located at 2408 East 81st Street, Tulsa, Oklahoma. A list of these physicians is available upon request. Your physician may refer you to Oklahoma Surgical Hospital because your physician believes it provides quality medical care. Oklahoma Surgical Hospital is a state-of-the-art surgical hospital that is convenient for patients in terms of location, access, scheduling and hours of operation. We believe the hospital's staff provides excellent service to patients. We recognize that you have a choice in the selection of the facility where you receive care. If you would prefer to obtain treatment at another hospital, please discuss it with your physician.

In the event you, the patient, decline to consent to release of your medical records by CSOS to your referring physician or your insurance company, you will be solely and individually responsible for picking up and delivering your medical records to all physicians or insurance companies requesting them, and for payment of such services that are denied due to insufficient records.

\_\_\_\_\_  
Signed (Patient, Parent or Authorized Person)

\_\_\_\_\_  
Date