Authorization for the Use and Disclosure of Protected Health Information

I authorize and direct Southern Texas Physicians Network and its employees, agents, servants, or representatives to release certain information and/or records from my medical records, including without limitation, my communicable disease status (such as HIV/AIDS, Hepatitis, or Tuberculosis) to the person(s) at the address (es) listed below:

_____

_____

_____

Unless otherwise revoked, I understand that the specific date or event upon which this authorization expires is one year from the date this authorization is signed unless another date is specified. Specification of date or event upon which this authorization and release expires:

_____

A photo static copy of this Authorization shall be considered as effective and valid as the original.

_____

_____ _____

Patient or Patient's Legal Representative*Signature Date

Notice of Privacy Practices

I acknowledge that I have received the medical practice's notice of privacy practices, which describes the ways in which the medical practice may use of, disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact the Privacy Officer of the medical practice if I have a question or complaint.

Acknowledge_____ (initials)

Consent to Treatment

I consent to the procedures which may be performed during this outpatient visit, which may include, but are not limited to, laboratory procedures, diagnostic procedures, blood and / or urine specimens for substance abuse (drug/alcohol) screenings, x-ray examination, medical or nursing treatment or other physician or clinic services rendered to me as ordered by my physician or other healthcare professional.

This consent includes testing for communicable or blood-borne diseases, including, without limitation, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), and Hepatitis if a physician orders such test(s) for diagnostic and/or treatment purposes.

I, as the patient, parent, guardian, spouse, guarantor, or agent of the patient, certify that I have read, or have had read to me, and understand this Consent to Treatment. I have signed this Consent to Treatment knowingly, freely, and voluntarily. I have received no promises, assurances or guarantees from anyone as to the results that may be obtained by any medical treatment or services.

_____ _____

Patient or Patient's Legal Representative*Signature Date

Print Name _____

If signed by other than patient, indicate relationship: _____

Authorized representative must submit copies of legal document supporting his/her authority to act on the patient's behalf

_____ _____

Witness Signature Date

Witness Print Name: _____

7/2010