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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____ Date of Birth: _____

Address: _____ Phone #: _____

SECTION B: PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your personal health information to carry out treatment, payment activities, and health operations.

Notice of Private Practices: You have the right to read our notice of private practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the use and disclosures we may make of your protected health information, and of other important manners about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Private Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain. You may obtain a copy of our Notice of Private Practices, including any revisions of our Notice, at any time by contacting our office manager:

Liza Linder at (830)249-8559

Right to revoke: You will have the right to revoke this consent at any time by giving us a written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this consent.

SIGNATURE: I _____, have had full opportunity to read and consider the content of this Consent form and you Notice of Private Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected information to carry out treatment, payment activities, and health care operations.

SIGNATURE: _____ DATE: _____

If this consent is signed by personal representative on behalf of the patient, complete the following personal representative's name: _____ relationship to patient: _____