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General Consent for Treatment

I have voluntarily presented for medical care and consent to such medical care and treatment including any diagnostic procedures and tests that the physician(s), his or her associates, assistants and other healthcare providers determine to be necessary. In the course of treatment, I understand and acknowledge that no warranty or guarantee has been or will be made as to the result or cure of treatment.

I consent to the taking of photographs or films related to the care and treatment and understand that such photographs or films may be made part of the medical record and/or used for internal purposes, such as performance improvement or education. **Test results will not be discussed over the phone.**

I have the legal right to consent to medical treatment because I am the patient or I am the parent/guardian of the patient. All references to "patient," "me," and "my" in this document means: *_______________________________ (name of patient).

Electronic Medical Records

Your child's records are shared with their primary care provider to allow and promote continuity of care. Your child's records will not be released to anyone else without your express consent.

Electronic Prescriptions (E-Prescribing)

I voluntarily authorize E-Prescribing for prescriptions, which allows heath care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispensing history as long as a physician/ patient relationship exists.

Acknowledgments

I acknowledge that administrative data, demographic information and other health information describing patient care, services and outcomes are collected and used for healthcare operations, governmental and non-governmental reporting.

I acknowledge that I have received a HIPAA Notice of Privacy Practices ("Notice"). The Notice explains how we may use and disclose the patient's protected health information for treatment, payment and health care operations purpose. "Protected health information" means the patient's personal health information found in the patient's medical and billing records. If you have questions about the Notice, please contact us at 512-472-6134.

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

Name of Patient: * ____

Patient's Date of Birth (MM/DD/YYYY): * __________________________

Signature of Patient (or responsible party if a minor): *____

Date: * __________________________

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