PATIENT INFORMATION (please print)

DOB: _____ SSN: _____ Marital Status: M S W D Sep

Name: _____ Sex: _____
Last name First name Middle initial

Address: _____
Street Name City State Zip Code

Home telephone: _____ Cellular phone: _____

Email address: _____

_____
Primary Care Physician Phone # Address

_____
Referring Physician Phone # Address

Patient's Employer: _____
Business Address: _____ Phone: _____

In case of an emergency please contact:
Name: _____ Relationship: _____
Last name First name Middle initial
Home telephone: _____ Alternate phone: _____

Primary Insurance Information:

_____
Name of Insurance Co. Telephone Number

Policyholder: _____ Guarantor's DOB: _____
ID Number: _____ Group Number: _____
Guarantor's SSN: _____ Relationship: _____

Secondary Insurance Information:

_____
Name of Insurance Co. Telephone Number

Policyholder: _____ Guarantor's DOB: _____
Policy Number: _____ Group Number: _____
Guarantor's SSN : _____ Relationship: _____

INSURANCE AUTHORIZATION AND MEDICAL RELEASE FORM

I HEREBY AUTHORIZE JAMES A. FIELD, M.D., AND/OR JASON BALETTE, M.D., AND/OR WOODLANDS SURGICAL ASSOCIATES, AND/OR URGENT SURGICAL GROUP OF TEXAS TO FURNISH OR OBTAIN MEDICAL RECORDS CONCERNING MY ILLNESS AND TREATMENT TO INSURANCE CARRIERS OR MEDICAL FACILITIES. I HEREBY ASSIGN TO THE PHYSICIAN ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MY DEPENDENTS OR MYSELF. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CHARGES REGARDLESS OF INSURANCE COVERAGE.
CO-PAYMENT IS TO BE PAID AT THE TIME OF YOUR OFFICE VISIT; AS WELL AS ANY DEDUCTIBLES.

_____ _____
SIGNATURE DATE

MEDICAL HISTORY TODAY'S DATE: _____

Name: _____ **Birthdate:** _____

REASON FOR VISIT: _____
_____

Allergies to Medications, X-Ray Dyes, or Other Substances ____NO ____YES
(If yes, please list name of medicine and type of reaction
_____ _____
_____ _____

Are you currently taking Aspirin or a medication that contains Aspirin (i.e. Bufferin, Goody Power, Indocin, etc.), an anti-inflammatory medicine (Motrin, Advil, Aleve, Nuprin, ect.) or Coumadin, Plavix or any other medication that may cause bleeding? YES NO

If yes, which one: _____

Occupation: _____

Past Medical History and Review of Systems
Please check off if **you** have had any problems with or are presently experiencing any of the following:

___High Blood Pressure	___Bronchitis	___Ulcers
___Diabetes	___Pneumonia	___Change in bowel habits
___Cancer	___Persistent cough	___Heart Disease
___T.B.	___Hemorrhoids	___ Gout
___Chest pain/tightness	___Hay fever	___Gallbladder disease
___Shortness of breath	___Abdominal discomfort	___Colitis
___ Swollen ankles	___Indigestion	___Hepatitis or jaundice
___Palpitations	___Nausea	___Thyroid disease
___Lightheadedness	___Vomiting	___Head or neck radiation
___Frequent urination	___Constipation	___Headache
___Rheumatic fever	___Diarrhea	___Kidney disease/stones
___Asthma	___Blood in stool	___Difficulty urinating
___Blood disorders	___Anxiety	___Depression
___Anemia	___Alcohol abuse	___Drug Abuse
___Unexplained weight gain/loss		___Sleep Apnea

Other:_____

Medication (prescribed OR over the counter, vitamins, herbal, etc.) Mark *NA* if none

Drug name	Drug name	Drug name
_____	_____	_____
_____	_____	_____
_____	_____	_____

PHARMACY INFORMATION

Patient Name:_____ DOB:_____

Preferred Pharmacy:_____

Phone #:_____

Address or Cross Street:_____

**If your preferred pharmacy is a home delivery service, please list an in-person pharmacy for urgent prescriptions:
In-person Pharmacy:_____
Phone #:_____
Address or Cross Street:_____

SIGNATURE_____ DATE_____

****NOTICE: Accurate pharmacy information is required in order to receive any pre or post-operative medication as prescriptions will only be sent to your pharmacy electronically. Once medications have been sent we will not be able to transfer them to another pharmacy.**

Name _____ **Birthdate** _____

MEDICAL HISTORY CONTINUES.
(This information is for use by your physician as part of your confidential medical record.)

List and add dates of:
Surgeries:

_____ _____ _____
_____ _____ _____
_____ _____ _____

Hospitalization other than surgery:

_____ _____ _____

Family History Example: diabetes, high blood pressure

Father _____

Grandfather _____

Grandmother _____

Mother _____

Grandfather _____

Grandmother _____

Siblings _____

Children _____

Social History/Prevention

Do you smoke? ____ Never ___ Current Quit (year):_____

Types used: Cigarettes Cigar Pipe Smokeless

Do you drink alcoholic beverages? ____Never ___Current Quit: _____

Types used: Beer Wine Liquor Amount per week: _____

Do you use drugs? ____ Never ___ Current Quit (year):_____

Flu immunization: ____ YES ___NO WHEN: _____ by _____

When was your last:

PAP smear _____ Breast exam _____ Colon cancer test _____
Cholesterol check _____ Mammogram _____ Prostate exam _____

Would you like your doctor to pray with you? YES NO

Surgical Group
Of The Woodlands

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy that we **require** you read and sign prior to any treatment.
All patients must complete our Information and Insurance form before seeing the doctor.

- **FULL PAYMENT IS DUE AT TIME OF SERVICE**
- **WE ACCEPT Cash, Checks, Visa, or MasterCard**

Regarding Insurance
We may accept assignment of insurance benefits. The balance is your responsibility whether your insurance company pays or not. We cannot bill your insurance company unless you give us your insurance information. **Your insurance policy is a contract between you and your insurance company**. **We are not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will automatically be transferred to you as the guarantor.** Please be aware that some, and perhaps all, of the services provided may be non-covered services and not be considered reasonable and necessary under the Medicare Program and/or other medical insurance, see attached ABN. Regarding Insurance Plans where we are a participating provider, all co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where we are not participating providers, refer to above paragraph.
Disclosure of Ownership:
Surgical Group of The Woodlands is a physician owned facility and your physician may have a financial interest in a surgery center, laboratory or other entity where you may be scheduled for treatment. You have the right to choose where you receive medical and surgical services including an entity in which your physician may have a financial relationship.
Usual and Customary Rates
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
Adult Patients
Adult patients are responsible for full payment at time of service.
Minor Patients
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment.
Surgery
Deductible, co-insurance and co-payments are due prior to surgery date, unless other arrangements have been made.

SIGNATURE _____ Date _____

Surgical Group Of The Woodlands

PATIENT QUESTIONNAIRE

I. Please list the family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment, and health care options):

NAME **RELATIONSHIP** **D.O.B**

_____

_____

II. Please list the family members or significant others, if any, whom we may inform about your medical condition ONLY IN AN EMERGENCY:

Name_____Phone_____
Name_____Phone_____

III. Please print the address of where you would like your billing statements and/or correspondence from our office to be sent if other than your home.

_____

_____

IV. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL". **YES_____ NO_____**

V. Please print the telephone number where you want to receive calls about your appointments, lab, and x-ray results, or other health care information if other than your home phone number: ( )_____
**** I am fully aware that a cell phone is not a secure and private line.***

VI. Can confidential messages (i.e., appointment reminders) be left on your home answering machine or voice mail? **YES_____NO_____**

VII. I am fully aware my health information can be transmitted by electronic transmission, by fax transmittal, by internet or email.

PATIENT NAME_____ (guardian if under 18 years)

PATIENT/GUARDIAN SIGNATURE_____ DATE_____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____D.O.B._____

SECTION B: TO THE PATIENT--PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

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

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your health information, and of other important matters about your health information. A copy of our Notice is available upon request. It is also posted in our office.

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 Privacy 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 Privacy Practices, including any revisions, at any time by contacting:

The Surgical Group of the Woodlands
9200 Pinecroft, Suite 250
The Woodlands, TX 77380
PH. (281)419-8400
FX. (281) 292-1972

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the address 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 your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____Date_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____ Relationship to patient_____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

At The Surgical Group of the Woodlands we are committed to treating and using protected health information about you responsibly. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your rights regarding medical information.
3. Follow the terms of the current notice.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facility directories: you name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: We may use and disclose medical information to notify or help notify; a family member, your personal representative or another person responsible for your care. We will share information about your location , general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgment to make decision in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: We may share medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Research in Limited Circumstances: We may use medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for nations security and intelligence activities, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may use and disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized or necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigation or proceedings, inspections, licensure or disciplinary actions or other similar programs.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws(such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official , reporting death, crimes on our premises and crimes in emergencies.

Appointment Reminders: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

Alternative and Additional Medical Services: We may use and disclose medical information to furnish you with information about health-related benefits and services that may be of interest to you, and to describe or recommend treatment alternatives.

Surgical Group Of The Woodlands

Consent for Use of Email Address

AUTHORIZATION FOR THE USE OF PATIENT'S EMAIL ADDRESS BY SGOTW PHYSICIANS, ITS AFFILIATED ENTITIES AND BUSINESS ASSOCIATES

SGOTW physicians are committed to protecting information you provide us. SGOTW Physicians creates a record of the information you provide us for use in your care and treatment and for communication with you. These records are maintained in a confidential manner, as required by law. SGOTW physicians, its professional staff and affiliated entities and business associates follow the privacy practices described in this consent and our Joint Notice of Privacy Practices.

You are requested to provide you email address to SGOTW physicians. The provision of your email address is entirely voluntary. Your email address may be used by SGOTW physicians, its affiliated entities and business associates for the following purposes.

- For appointment reminders.
- To inform you of benefits and services related to your health.
- Through the use of online surveys emailed to you by SGOTW physicians, its affiliated entities and business associates, to allow you to communicate your opinion of our staff, facilities and services received.
- As required by law and for certain law enforcement activities.
- As otherwise described in our Joint Notice of Privacy Practices.

Except as described above, we will not use or disclose your email address unless you authorize (permit) SGOTW physicians in writing to disclose your email address. If you initially give permission, you may revoke that permission, which will be effective only after the date of your written revocation.

As the patient email addresses SGOTW Physicians collects will be assembled into a mailing list, group mailings will not be sent in a manner in which recipients are visible to one another.

To the extent permitted by law, the undersigned agrees to indemnify and hold harmless SGOTW physicians, its affiliated entities and business associates from and against all claims, demands, liabilities, judgments or causes of action of any nature for any relief , elements of recovery or damages recognized by law (including, without limitation, attorney's fees, defense costs, and equitable relief), for any damage or loss incurred by the undersigned arising out of, resulting from, or attributable to any acts or omissions or other conduct of SGOTW physicians, its affiliated entities or business associates. These indemnities shall survive the revocation of this consent.

Declaration: I have read and understand the about agreements and authorizations. The terms and consequences of this document have been fully explained to me and I have signed it freely and without inducement other than the rendition of services. All of my questions have been fully answered.

Patient's (or Patient's Legal Representative's) **Email Address:_____@_____**

Signature of Patient (or Patient's Legal Representative): _____

Printed Name of Patient: _____

Printed Name of Legal Representative (if any) _____

Representative's Authority to Act for Patient: _____

THE SURGICAL GROUP OF THE WOODLANDS

**JAMES A. FIELD, M.D., F.A.C.S., JASON BALETTE, M.D., F.A.C.S.,
JAMES R. MAGGART, M.D., F.A.C.S., DREW D. HOWARD, M.D., F.A.C.S.,
SAYL BUNYAN, M.D., F.A.C.S., TIMOTHY HODGES, M.D., F.A.C.S.,
BRADLEY WAGGONER, M.D., F.A.C.S., PAUL EVANS, M.D., F.A.C.S.**

9200 PINECROFT SUITE 250
THE WOODLANDS, TX 77380
OFFICE (281) 419-8400
FAX (281) 292-1972 ALT FAX (346) 331-2194

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name: _____ Date of Birth: _____

Phone: _____ SSN: _XXX - XX_____

Above listed patient authorizes the following healthcare provider or facility to make record disclosure to Surgical Group and allows Surgical Group of The Woodlands to make record disclosure to the following healthcare provider or facility.

Provider/Facility/Doctor Name: _____

Facility Phone: _____ **Facility Fax:** _____

Dates and Type of information to disclose:

- **Visit encounter notes**
- **Labs**
- **Radiology/ Imaging reports**
- **Operative reports**
- **Surgical pathology reports**
- **Entire record**
- **Specific information requested:** _____

The purpose of disclosure is:

- **Change of physician**
- **Continuation of care**
- **Referral**
- **Legal**
- **Insurance**
- **Other:** _____

RESTRICTIONS: Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date on this authorization unless other dates are specified.

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

- _____ I authorize this information to be disclosed to Surgical Group of The Woodlands.
- _____ I do not authorize this information to be disclosed to Surgical Group of The Woodlands.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

This authorization will expire on the following date: _____. **If no expiration date is specified, this authorization will expire 1 year from the date signed.**

X_____ _____

Signature of Patient/ Parent / Guardian or Authorized Representative Date

_____ _____

Printed Name of Authorized Representative Relationship to patient

Patient Consent for My Provider to
File an Appeal on my Behalf with my Health Insurance Plan

Provider Name:	**Provider Plan ID Number:**
Provider Address:	
Description of services that may be appealed:	**Date(s) services were provided:**

I agree to allow this health care provider file an appeal on my behalf with the following health plan if there is a question about coverage for the services listed below.

I understand that:

1. If I consent, I will not be able to file my own appeal concerning these same services, nor will any representative I appoint, unless this consent is rescinded in writing.
2. I have a right to rescind this consent at any time. My legal representative has the right to rescind this consent at any time.
3. This consent shall be automatically rescinded if my health care provider does not file an appeal, or stops appealing my case.

I have read this consent or have had it read to me, and it has been explained to my satisfaction.

I understand the information in the consent form, and grant my consent to this provider to file an appeal on my behalf.

Print Patient Name:	**Patient Date of Birth:**	**Health Insurance Company**:
Patient Address:	**Patient Insurance ID Number:**	
Patient Signature:	**Signature Date:**	

The above name enrollee is unable to sign this consent form because of the following reasons and I consent for the above named enrollee:

Print Representative Name:	**Relationship to the Patient:**
Representative Signature:	**Signature Date**:

Print Witness Name:	**Witness Signature:**	**Signature Date:**

MEMORIAL HERMANN INFORMATION EXCHANGE "MHiE"
PATIENT CONSENT FOR THE USE AND DISCLOSURE OF HEALTH INFORMATION

Purpose: The MHiE is a health information exchange network developed by Memorial Hermann Health System. Exhange Members include hospitals, physicians and other healthcare providers. Exchange Members are able to share electronically medical and other individually identifiable health information about patients for treatment, payment and healthcare operation purposes. We are an Exchange Member of the MHiE and we seek your permission to share your health information with other Exchange Members via the MHiE. By executing this form, you consent to our use and electronic disclosure of your health information to other MHiE Exchange Members for treatment, payment and healthcare operation purposes. We will not deny you treatment or care if you decline to sign this Consent, but we will not be able to electronically share your health information with your healthcare providers that participate in the MHiE as Exchange Members if you do not sign this Consent.

Instructions: If you agree to allow us to disclose your health information with other MHiE Exchange Members please complete the relevant portions of and sign this Consent.

Patient Name (Last, First, Middle)	Date of Birth

Information that will be Disclosed; Purpose of the Consent for Disclosure

I, _____[Patient Name], hereby consent to the disclosure of my medical, health and encounter information by any and all Memorial Hermann Health System Providers (collectively the "Provider") to other participating providers in the MHiE (Exchange Members) who may request such information for treatment, payment or healthcare operation purposes. I understand the information to be disclosed includes medical and billing records used to make decisions about me.

I HEREBY SPECIFICALLY AUTHORIZE PROVIDER TO RELEASE ALL TYPES AND CATEGORIES OF PROTECTED HEALTH INFOMRATION TO OTHER HEALTHCARE PROVIDERS THAT PARTICIPATE IN THE MHiE FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATION PURPOSES, [INCLUDING BUT NOT LIMITED TO, YOUR ALCOHOL AND TREATMENT RECORDS, YOUR DRUG ABUSE TREATMENT RECORDS, YOUR MENTAL HEATH RECORDS, AND Y OUR HIV/ACQUIRED IMMUNE DEFICIENCY SYNDROME RECORDS, AS APPLICABLE].

No Conditions: This Consent is voluntary. We will not condition your treatment on receiving this Consent. **HOWEVER, IF YOU DO NOT SIGN [AND INITIAL] THIS CONSENT, WHERE REQUIRED, YOU CANNOT PARTICIPATE IN THE MHIE.**

Effect of Granting this Consent: This Consent permits all MHiE Exchange Members to access your health information. Exchange Memvers of the MHiE are hereby release from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein.

Term and Revocation

This Consent will remain in effect until you revoke it. You may revoke this Consent at any time by completing the MHiE notice of revocation. The MHiE notice of revocation is available by calling 713-456-MHiE (6443). Revocation of this consent will also have no effect on your person health information made available to Exchange Members during the time frame in which your Consent was active.

INDIVIDUALS'S SIGNATURE

I have had full opportunity to read and consider the contents of this Consent. I understand that, by signing this Consent, I am confirming my consent and authorization of the use and/or disclosure of my personal health information, as described herein.

Patient / Guardian Signature	Print Name	Relationship to patient	Date

Patient unable to sign due to: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT. Include this Consent in the individual's records.

Official Use Only:

MEMORIAL HERMANN
Information Exchange Patient Consent For The Use And Disclosure