Patient Id # _____ **Patient Name: _____**

Consent for Treatment

I, the undersigned, hereby consent to the following: Administration and performance of general treatment use of prescribed medications, performance of diagnostic procedures/tests and cultures, performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees. I fully understand this consent is given in advance of any specific diagnosis or treatment. I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing. I understand that this form may include consent at other satellite offices under common ownership. A photocopy of this consent shall be considered as valid as the original. I hereby authorize Texas Institute for Neurological Disorders to use and/or disclose my health information which specifically identifies me or which can reasonably be used to identify me to carry out my treatment, payment and healthcare operations as described in the Notice of Privacy Practices. I understand that while my consent is voluntary, if I refuse to sign this consent, the healthcare providers of Texas Institute for Neurological Disorders may refuse to treat me. I understand that these services are voluntary and that I have the right to refuse these services.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patient Signature (Parent/Legal Guardian):_____Date:_____

Patient Name (If Minor): _____

******I acknowledge that I have received or been given the opportunity to receive a copy of the HIPAA Privacy Policies and understand that if I have any questions or complaints, I should contact the Administrator.**

Patient Initials: _____

RELEASE OF MEDICAL INFORMATION

Please let us know how you would like us to communicate with you.
What information may we release: **(Check All That Apply)**

_____ All Personal Health Information
_____ Office Notes
_____ Lab/Diagnostic test results
_____ Appointment Information
_____ Billing Information
_____ Psychotherapy/mental health
_____ Prescription
_____ Other: _____

How may we release this information?

_____ Phone **#:_____**
_____ Fax #: _____
_____ Mail: Address: _____

Please let us know the name(s) with whom we may discuss health information or who may be allowed to enter the exam room during discussion regarding health information. I understand that I may request individual to leave the exam room at any time.

Name of Person(s) allowed in the examination room:

_____ _____

_____ _____

Name of Person(s) authorized to receive information:

_____ _____

_____ _____

**** If the requestor/receiver of information is not a healthcare provider, the released information may no longer be protected from re-disclosure****

Patient Signature: _____ Date: _____