Texas Medical & Surgical Associates, P.A.
8440 Walnut Hill Lane, Suite 120
Dallas, Texas 75231
Phone (214)345-1400 I Fax (214)345-1472

PATIENT CONSENT AND ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

I understand that as part of the provision of healthcare services, Texas Medical & Surgical Associates, PA creates and maintains health records and other information describing among other things, my health history, symptoms, examination, and test results, diagnoses, treatment, and any plans for future care or treatment.

I have been provided with a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing this consent. I understand that the organization reserves the right to change their privacy practices and the terms of this notice at any time. Upon your request, we will provide you with any revised Notice of Privacy Practices. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and healthcare operations. I have the right to revoke this consent in writing, except where disclosures have already been made in reliance on my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or healthcare operations without my prior written authorization, except as otherwise provided by law.

2. A photocopy or fax of this consent is as valid as the original.

3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or healthcare operations be restricted. I also understand that the Practice and I must agree to any restrictions in writhing that I request on the use and disclosure of my Protected Health Information which have been previously agreed upon.

______________________________	______________________________
PATIENT OR PERSONAL REPRESENTATIVE OR GUARDIAN'S NAME PRINTED	DATE
______________________________	______________________________
PATIENT OR PERSONAL REPRESENTATIVE OR GUARDIAN'S SIGNATURE	SOCIAL SECURITY NUMBER (FOR IDENTIFICATION PURPOSES ONLY)
______________________________	______________________________
WITNESS	DATE