I understand that as part of my health care, Brazosport Regional Family Medicine Center originates, records and maintains protected health information about me describing my health history, symptoms, examination and test results, diagnoses, treatment, and plans for future care or treatment. I understand that this protected health information may be used and disclosed by Brazosport Regional Family Medicine Center for treatment, payment and health care operations. For example, my protected health information serves as:

- **A basis for planning my care and treatment;**
- **A means of communication among the many health professionals who contribute to my care;**
- **A source of information for applying my diagnosis to my bill;**
- **A means by which a third-party payer can verify that services billed were actually provided; and**
- **A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals.**

I acknowledge that I have been provided with Brazosport Regional Family Medicine Center's Notice of Privacy Practices that provides me a more complete description of information uses and disclosures. I understand that I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand that Brazosport Regional Family Medicine Center reserves the right to change its Notice of Privacy Practices and a revised copy will be given to me at my next visit at Brazosport Regional Family Medicine Center. Initial: _____ Date received: _____

I understand that I have the right to request restrictions as to how my protected health information may be disclosed to carry out treatment, payment or health care operations. Brazosport Regional Family Medicine Center is not required to agree to the restrictions as requested, but if it does, it is bound by such restrictions.

I understand that I may revoke this consent in writing, except to the extent that Brazosport Regional Family Medicine Center has already taken action in reliance thereon.

By signing this form, I consent to Brazosport Regional Family Medicine Center's use and disclosure of my protected health information for treatment, payment and health care operations.

Patient Name (Please Print): _____ Date: _____

Signature of Patient/Legal Representative: _____ Date: _____

Witness: _____ Date: _____

Notice Effective Date: _____

CONSENT TO MEDICAL TREATMENT

I, (for) the undersigned patient, do hereby voluntarily consent to such care involving routine diagnostic procedures and medical treatment by Brazosport Regional Family Medicine Center. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me concerning the results of any treatment or examinations to be rendered during this visit.

Patient Name (Please Print): _____ Date: _____

Signature of Patient/Legal Representative: _____ Date: _____

Witness: _____ Date: _____