Place Label Here or Enter Info:

Patient Name: ____________________

____

MRN or DOB: ____________________

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form, you acknowledge that you have received a copy of the Notice of Privacy Practices. This notice explains how your health information will be handled. HIPAA, the Federal law concerning medical privacy, requires this notice.

I have received a copy of the Notice of Privacy Practices. UTHealth and UTP have given me the opportunity to ask questions about this notice and all of my questions have been answered.

____
Patient or Guardian Signature

____
If Guardian, Relationship to Patient

____
Date Signed

Provider Use Only

If patient was not able to sign due to an emergency, or did not want to sign, please document if patient was given the notice and the reason why the patient did not sign below.

Patient was given notice: _____Yes _____Refused

Reason signature was not obtained: ____

____

____

______________________________ ______________________________

Staff Signature Date

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TELEMEDICINE CONSENT

Patient Name: ______________________________ MRN: ______________________

1. I have an existing medical treatment relationship with ______________________________
   Provider
2. I wish to engage in a telemedicine visit with Provider.
3. Provider (and/or his or her office staff) has explained to me that the video conferencing technology will be used to affect such a telemedicine visit will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider. I authorize the electronic transmission of my medical information and/or video conference session so that it can be viewed by a health care professional and other persons involved in my medical or mental health care.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties.
5. I understand that my health care provider or I can discontinue the telemedicine visit if it is felt that the videoconferencing connections are not adequate for the situation.
6. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the visit other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room; and or (3) terminate the visit at any time.
7. I have had the alternatives to a telemedicine visit explained to me, and in choosing to participate in a telemedicine visit, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider. I understand that if I do not choose to participate in a telemedicine session, no action will be taken against me that will cause a delay in my care and that I may still pursue face-to-face consultation.
8. In an emergent visit, I understand that the responsibility of the telemedicine specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.
9. I understand that Provider may bill me for this telemedicine visit.
10. I have had a direct conversation with Provider and/or his or her office staff, during which I had the opportunity to ask questions regarding my receiving a health care consultation via video conferencing technology. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
11. By signing this form, I certify that:
    - I have read or had this form read and/or had this form explained to me;
    - I fully understand its contents including the risks and benefits of the telemedicine visits;
    - I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction; and
    - I consent to participate in this telemedicine visit.

Patient/Legal Guardian Signature / Initials (must be over 18 years of age)	Date/Time	Interpreter Name and ID (if necessary)
Print Name	If Legal Guardian, state relationship to patient	
Guarantor/Insured Signature / Initials (if different from above)	Date/Time	Print Name and Relationship to Patient
Witness Signature	Print Name	Date/Time

UT ★ Physicians

ACKNOWLEDGEMENT OF RECEIPT OF FINANCIAL RESPONSIBILITIES **Initials _____**

I acknowledge that I have received a copy of the Statement of Financial Responsibility. The statement is an explanation of required financial responsibility for the payment of the Patient's account.

DECLARATION

I have read and understand the above 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. All of my questions have been fully answered.

Patient/Legal Guardian Signature / Initials (must be over 18 years of age)	Date/Time	Interpreter Name and ID (if necessary)
Print Name	If Legal Guardian, state relationship to patient	
Guarantor/Insured Signature / Initials (if different from above)	Date/Time	Print Name and Relationship to patient
Witness Signature	Print Name	Date/Time

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CONSENT FOR MEDICAL TREATMENT, DISCLOSURES, AND WAIVERS

CONSENT FOR MEDICAL CARE AND TREATMENT

Knowing that I (the Patient) or the legal guardian (of the Patient) have (has) a condition requiring medical care, I hereby voluntarily consent to such care encompassing examinations, diagnostic procedures and medical treatment by the Patient's physician, his/her assistants and consignees as may be necessary in their judgment. I acknowledge that no guarantees have been made as to the result of diagnostic procedures, medical treatments or examinations by UT Physicians clinicians.

The Patient is under the care and supervision of the Patient's attending physician and consultants selected by this physician. It is the responsibility of UT Physicians and its staff to carry out the instructions of these physicians.

PATIENT RESPONSIBILITIES

In order to receive proper care, Patients must accept certain responsibilities. Patients and/or their legal guardians are responsible for providing accurate and complete information about matters relating to the Patient's health and for reporting changes in the Patient's condition. Patients and/or their legal guardians are responsible for following the treatment plan recommended for the Patient and reporting any side effects to the Patient's physician(s) and/or nurse(s). If treatment is refused or the directions of Patient's physician(s) are not followed, Patients and/or their legal guardians are responsible for their actions and the consequences of those actions. Patients and/or their legal guardians and their visitors are responsible for following the physician office guidelines and for being considerate of the rights of others while in the physician office (for example, assisting in the control of noise, not smoking, limiting the number of visitors, etc.)

PATIENT CONCERNS

Our staff strives to provide excellent care and service, and we hold ourselves to the highest personal and professional standards. If we fail to meet your expectations in any way, please do not hesitate to let us know as soon as possible. Rest assured that voicing a concern will never adversely affect the care and service we provide. If there is a problem, we want to correct it. Usually, a word to any staff member is all that is needed, but if you prefer, you may call Patient Relations at 713-486-1875 to speak confidentially with a patient representative or you may email patientexperience@uth.tmc.edu. Your question or concern will be promptly addressed. UT Physicians appreciates the opportunity to assist you and to make your visit as pleasant as possible. You also have the right to register a complaint with Health Care Financing Administration, Texas Medical Board and/or Texas Department of Insurance.

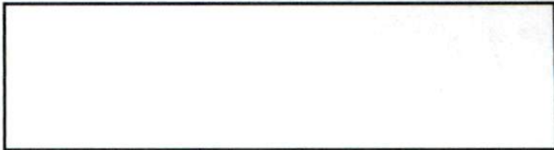
AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

I authorize UT Physicians to release any medical information including diagnostic, x-rays, test results, reports and records pertaining to any treatment or examination rendered to the Patient. I understand that this medical information may be used for any of the following purposes: diagnostics, insurance, legal and at times when the attending physician deems it necessary in order to ensure the best medical care on my behalf. I authorize UT Physicians and the Patient's physician(s) to disclose the Patient's health care information to any entity specified in UT Physician's Joint Notice of Privacy Practices. I further understand that any person(s) that receive(s) these medical records will not release any of the medical information disclosed by this authorization to any other person or organization without authorization signed by me for release of the information.

AUTHORIZATION TO CONTACT USING TELEPHONE, CELLULAR, AND/OR ELECTRONIC COMMUNICATIONS

I authorize UT Physicians and/or any third party organization assigned to the account to contact me at the telephone number, cellular number or email provided. Contact regarding my account may be performed with the use of pre-recorded messages, automatic dialing services, electronic email, text messaging, artificial voice messaging or personal calls regarding health care related notices or my obligation of payment for services.

UT PHYSICIANS CARDIOVASCULAR
6700 WEST LOOP SOUTH, SUITE 110
BELLAIRE,TEXAS 77401
713-572-8122
713-622-1493



TEST RESULT NOTIFICATION POLICY

All test results must be reviewed by your physician prior to your notification.

Non Urgent Test Results- Will be sent to you within 3 weeks of your test(s) date. Please do not call before then.

Please make sure that your correct address and telephone number are on file each time you visit your doctor. Failure do so could cause a delay in your receipt of your test results.

Urgent Test Results- You will be contacted by your doctor via the telephone.

If you wish to be contacted in the following manner(check all that applies):

1. Home Telephone #:_________________________________
   - ☐ It's ok to leave messages with detailed information.
   - ☐ Leave messages with a call back number only.
   - ☐ Ok to leave information with____________________

2. Work Telephone or Cell Phone #:______________________
   - ☐ It's ok to leave messages with detailed information.
   - ☐ Leave messages with a call back number only.
   - ☐ Ok to leave information with____________________

3. Written Communication will be mailed to:
   Address:__________________________Apt#_____
   City:_____________State:__________Zip_______

4. Fax Results to:_____________________________________

____

Patient:____DOB______________
(Print Name)
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 Healthcare System. Exchange 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 Healthcare 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 INFORMATION 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 HEALTH RECORDS, AND YOUR 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 Members of the MHiE are hereby released 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 *not* affect any action we took in reliance on this Consent before we received your notice of revocation. Revocation of this Consent will also have no effect on your personal health information made available to Exchange Members during the timeframe in which your Consent was active.

INDIVIDUAL'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.

Signature: ______________________ Date: ______________________

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

Personal Representative's Name: ______________________

Relationship to Individual: ______________________

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

Official Use Only:

INTERCAMBIO DE INFORMACIÓN DE MEMORIAL HERMANN (MHiE) CONSENTIMIENTO DEL PACIENTE AL USO Y LA DIVULGACIÓN DE INFORMACIÓN SOBRE SU SALUD

Propósito: El MHiE es una red para el intercambio de información sobre la salud desarrollada por Memorial Hermann Healthcare System. Los Miembros de intercambio incluyen hospitales, médicos y otros proveedores de cuidado médico, que pueden compartir electrónicamente la información médica y otra información sobre la salud individualmente identificable acerca de los pacientes, con fines de tratamiento, pago y operación de sistemas de cuidado de la salud. Nosotros también somos Miembros de intercambio de MHiE y solicitamos su autorización para compartir la información sobre su salud con otros Miembros a través de MHiE. Al firmar este formulario, usted da su consentimiento a nuestro uso y divulgación electrónica de la información sobre su salud a otros Miembros de intercámbio de MHiE con fines de tratamiento, pago y operación de sistemas de cuidado de la salud. Si usted rechaza firmar este Consentimiento, no nos negaremos a brindarle tratamiento o cuidado. Sin embargo, si usted no lo firma, no podremos compartir electrónicamente la información sobre su salud con sus proveedores de cuidado de la salud que participan en el MHiE como Miembros de intercambio.

Instrucciones: Si usted acepta permitirnos que divulguemos la información sobre su salud a otros Miembros de intercambio de MHiE, llene las partes correspondientes de este Consentimiento y fírmelo.

Nombre del paciente (apellido, primer nombre, segundo nombre)	Fecha de nacimiento

Información que se divulgará; propósito del Consentimiento para la divulgación

Yo, ______________________________ [nombre del paciente], por este medio doy mi consentimiento a la divulgación de mi información médica, de salud y de visitas a todos y cada uno de los proveedores del Memorial Hermann Healthcare System (colectivamente denominados el "Proveedor") a otros proveedores participantes en el MHiE (Miembros de intercambio) que soliciten tal información con fines de tratamiento, pago y operación de sistemas de cuidado de la salud. Entiendo que la información a divulgar incluye registros médicos y de facturación utilizados para tomar decisiones acerca de mi persona.

POR ESTE MEDIO AUTORIZO ESPECÍFICAMENTE AL PROVEEDOR A REVELAR TODOS LOS TIPOS Y CATEGORÍAS DE INFORMACIÓN PROTEGIDA SOBRE MI SALUD A OTROS PROVEEDORES DE CUIDADO DE LA SALUD PARTICIPANTES EN MHiE, CON FINES DE TRATAMIENTO, PAGO Y OPERACIÓN DE SISTEMAS DE CUIDADO DE LA SALUD [LO CUAL INCLUYE, SIN LIMITACIÓN, MIS REGISTROS SOBRE ALCOHOL Y TRATAMIENTO, ABUSO DE DROGAS, SALUD MENTAL Y VIH/SÍNDROME DE INMUNODEFICIENCIA ADQUIRIDA, SEGÚN CORRESPONDA].

Ausencia de condiciones: Este Consentimiento es voluntario. No condicionaremos su tratamiento a la recepción de este Consentimiento. **NO OBSTANTE, SI USTED NO LO FIRMA [O NO ANOTA SUS INICIALES] EN LOS LUGARES CORRESPONDIENTES, NO PODRÁ PARTICIPAR EN MHiE.**

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

Plazo de vigencia y revocación Este Consentimiento continuará siendo válido a menos que usted lo revoque. Usted puede revocar este Consentimiento en cualquier momento completando la notificación de revocación de MHiE. Para obtener una notificación de revocación de MHiE, llame al 713-456-MHiE (6443). La revocación de este Consentimiento *no* afectará ninguna medida que hayamos tomado basándonos en este Consentimiento antes de recibir su notificación de revocación. Asimismo, tal revocación no tendrá ningún efecto sobre la información personal sobre su salud que ya se haya hecho disponible a los Miembros de intercambio durante el plazo en el cual su Consentimiento haya estado vigente.

FIRMA DEL PACIENTE

He tenido la oportunidad de leer y considerar el contenido de este Consentimiento. Entiendo que, al firmarlo, confirmo mi autorización y consentimiento para el uso y la divulgación de la información personal sobre mi salud, tal como se describe en este documento.

Firma:______________________________ Fecha:____________________

Si este Consentimiento es firmado por un representante personal en nombre de la persona, complete lo siguiente:

Nombre del representante personal: ______________________________

Relación o parentesco con el paciente: ______________________________

USTED TIENE DERECHO A RECIBIR UNA COPIA DE ESTE CONSENTIMIENTO DESPUÉS DE FIRMARLO.
Incluir este Consentimiento en los registros del paciente.

Official Use Only:

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This authorization remains in effect unless and until you revoke it. You can revoke this authorization at any time by giving written notice to UT Physicians at **6410 Fannin, LL100, Houston, TX 77030** or **Fax 713-512-2252**. Your revocation will be effective within (3) days. You understand that revoking this authorization does not impact PHI previously shared when your authorization was in effect.
You understand that when your PHI is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by state or federal privacy regulations.

Patient Name ______________________ Date ______________________

Signature of Authorized person ______________________

Name (if different patient) ______________________ Relationship ______________________

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Authorization for the Use and Disclosure of PHI with Greater Houston Healthconnect

UT Physicians participates in Greater Houston Healthconnect, a non-profit organization that provides a secured electronic network of Healthconnect participants, including doctors' offices, hospitals, labs, pharmacies, radiology centers and payors of health claims, such as health insurers, to share your protected health information(PHI). A list of current Healthconnect participants is available at www.ghhconnect.org. When you join Healthconnect, your doctors can electronically search all Healthconnect participants for your PHI and use it while treating you. Healthconnect does not change which providers get to see your information—it allows your information to be shared in a new way. All Healthconnect participants must protect your privacy in accordance with state and federal laws.

Your treatment will not be affected in any way should you choose not to join Healthconnect.

By signing this authorization, you agree that UTPhysicians, Healthconnect and its current and future participants may use and disclose your PHI electronically through Healthconnect **for the limited purpose of treatment, payment and healthcare operations.** You understand that Healthconnect may connect to other health information exchanges in Texas and across the country that also must protect your privacy in accordance with state and federal laws, and you authorize Healthconnect to share your information with those exchanges for the same limited purposes.

Your health information that may be shared through Healthconnect includes:

- Diagnosis (disease or problem)
- Clinical summaries of treatment and copies of documents in your medical record
- Results of laboratory tests, X-rays and other tests
- Medication (current and in the past)
- Personal information such as name, address, telephone number, gender, ethnicity and age
- Names of providers and dates of service
- Alcohol, drug abuse, mental and behavioral health treatment
- HIV/Acquired Immune Deficiency Syndrome (AIDS) test results and treatment
- Hepatitis B or C test results and treatment
- Genetic test results and treatment
- Genome information, if provided
- Family medical history, if provided

You understand that the records used and disclosed pursuant to this authorization may include information relating to: Human Immunodeficiency Virus (HIV) infection or Acquired Immunodeficiency Syndrome (AIDS); treatment for or history of drug or alcohol abuse; or mental or behavioral health or psychiatric care.