UT★Physicians
ORTHOPAEDICS

NEW PATIENT HISTORY

Patient Name ______________________ Age __________ Date __________

Occupation ______________________ ☐ Male ☐ Female DOB __________

Who may we thank for your referral: ______________________

Current Problem: ______________________ ☐ Left ☐ Right Date Current Problem Began: __________

Are you experiencing any of the following: (check)

☐ Pain ☐ Swelling ☐ Redness ☐ Limited Motion ☐ Muscle Weakness ☐ Loss of Muscle ☐ Cramps

☐ Popping ☐ Locking/Catch ☐ Stiffness ☐ Numbness ☐ Tingling ☐ Mass ☐ Deformity

---

Have you been treated for this problem before? ☐ No ☐ Yes What kind of treatment: ☐ Medication ☐ Injection

☐ Splint/Brace ☐ Therapy ☐ Surgery ☐ X-rays ☐ MRI ☐ Nerve Test ☐ Other: __________

Are you Allergic to any medications? ☐ No ☐ Yes List: __________

Have you ever had an adverse reaction to a blood transfusion? ☐ No ☐ Yes

Do you have an allergy to tape or adhesives? ☐ No ☐ Yes Have you ever had problems with anesthesia? ☐ No ☐ Yes

Have you ever been hospitalized or had surgery? ☐ No ☐ Yes

Surgery Type	Date	Surgery Type	Date

CURRENT MEDICATIONS

Please list all medication you are currently taking, including aspirin, herbal remedies, and any over-the-counter medications, (If you are taking more than 6 medications, continue on reverse side or separate sheet)

Medication	Strength	How Often Taken

Have you ever used steroid medications (cortisone, prednisone, etc.) No [ ] Yes [ ]

HABITS

Tobacco Use ☐ No ☐ Yes Type and Amount per Day __________

Alcohol Use ☐ No ☐ Yes Type and Frequency __________

Drug Use ☐ No ☐ Yes Type and Frequency __________

Caffeine Use ☐ No ☐ Yes Type and Frequency __________

Exercise ☐ No ☐ Yes Type and Frequency __________

HEALTH

Do you have, or have you ever had, any of the following? Check all that apply:

☐ AIDS/HIV+
☐ Arthritis, Bursitis
☐ Asthma
☐ Back Pain
☐ Blood Clots
☐ Cancer
  ☐ Benign __________
  ☐ Malignant __________
☐ Depression
☐ Diabetes (Sugar)
  ☐ Insulin
  ☐ Oral Medications
  ☐ Regulated by Diet
☐ Epilepsy or Seizures
☐ Excessive Bleeding
☐ Gallbladder Trouble

☐ Glaucoma
☐ Gout
☐ Hay Fever
☐ Heart attack
☐ Heart Disease
☐ Hemorrhoids
☐ Hepatitis or Jaundice
☐ Hernia
☐ Hypertension / High Blood Pressure
☐ Infection
  ☐ Staph __________
  ☐ MRSA __________
  ☐ Other __________
☐ Kidney Disease
☐ Kidney Stone

☐ Leukemia
☐ Loss of any part of arm/leg
☐ Lung Disease
☐ Osteoporosis
☐ Palsy
☐ Pancreatitis
☐ Pneumonia
☐ Psoriasis
☐ Psychiatric treatment
☐ Pulmonary Embolism
☐ Rheumatoid Fever
☐ Scarlet Fever
☐ Strokes

☐ TB
☐ Thyroid Disease
☐ T.I.A.
☐ Tumor / Growth / Cyst
☐ Ulcer - Gastric
☐ Ulcer - Peptic
☐ Venereal Disease
☐
☐
☐
☐ Other __________
☐ __________
☐ __________

Females Only

Are you pregnant? ☐ No ☐ Yes

Have you had a baby within the last month? ☐ No ☐ Yes

Are you currently taking birth control pills? ☐ No ☐ Yes How long? __________

Are you on hormone therapy? ☐ No ☐ Yes Name: __________ Dose: __________

Who is your primary care physician: ______________________ Phone: ______________________

REVIEW OF SYSTEMS: (Check all that you have experienced recently). ALL QUESTIONS MUST BE ANSWERED

General

No	Yes	
☐	☐	Weight loss
☐	☐	Weight gain
☐	☐	Poor appetite
☐	☐	Chills
☐	☐	Fever
☐	☐	Night Sweats

Skin

No	Yes	
☐	☐	Rash
☐	☐	Hives
☐	☐	Lesions

Head/Eyes/Ears/Nose/Throat

No	Yes	
☐	☐	Hay fever
☐	☐	Postnasal drip
☐	☐	Hoarseness
☐	☐	Visual problems
☐	☐	Nose bleeds
☐	☐	Neck stiffness/pain

Psychiatric

No	Yes	
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Other __________

Pulmonary

No	Yes	
☐	☐	Shortness of breath
☐	☐	Wheezing
☐	☐	Coughing
☐	☐	Coughing up blood

Genitourinary

No	Yes	
☐	☐	Frequent urination (frequency)
☐	☐	Urgent urination (urgency)
☐	☐	Painful urination (dysuria)
☐	☐	Need to awaken to urinate
☐	☐	Blood in urine
☐	☐	Penile or vaginal discharge
☐	☐	Kidney stone pain

Gastrointestinal

No	Yes	
☐	☐	Indigestion
☐	☐	Gas
☐	☐	Nausea
☐	☐	Vomiting
☐	☐	Vomiting blood
☐	☐	Yellow skin
☐	☐	Abdominal pain
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Black stools
☐	☐	Rectal bleeding

Musculoskeletal

No	Yes	
☐	☐	Pain
☐	☐	Swelling
☐	☐	Redness
☐	☐	Limited motion
☐	☐	Weakness
☐	☐	Atrophy
☐	☐	Cramps
☐	☐	Popping
☐	☐	Locking/catching
☐	☐	Stiffness
☐	☐	Numbness
☐	☐	Tingling
☐	☐	Mass
☐	☐	Deformity

Lymphatics

No	Yes	
☐	☐	Lymph node swelling
☐	☐	Node tenderness

Endocrine

No	Yes	
☐	☐	Excessive urination
☐	☐	Excessive thirst
☐	☐	Excessive appetite
☐	☐	Hot intolerance
☐	☐	Cold intolerance
☐	☐	Easy bleeding

Cardiovascular

No	Yes	
☐	☐	Chest pain (angina)
☐	☐	Palpitations (rapid heartbeat)
☐	☐	Irregular heartbeat (arrhythmia)
☐	☐	Rheumatic fever
☐	☐	Swollen ankles (pedal edema)
☐	☐	Shortness of breath on exertion
☐	☐	Shortness of breath at night
☐	☐	Neurological
☐	☐	Loss of consciousness
☐	☐	Headaches
☐	☐	Dizziness
☐	☐	Seizures (fits)
☐	☐	Fainting spells

Height ______________________

Weight ______________________

Dominance

☐ Right Hand

☐ Left Hand

FAMILY HEALTH Have blood relatives ever had one of the following? If so, indicate their relationship to you (e.g. Diabetes - maternal grandmother)

No	Yes		No	Yes		No	Yes		No	Yes	
☐	☐	Diabetes	☐	☐	Liver Trouble	☐	☐	Arthritis	☐	☐	Psychiatric Disease
☐	☐	Tuberculosis	☐	☐	High Blood Pressure	☐	☐	Cancer	☐	☐	Unusual Reaction to Anesthesia
☐	☐	Heart Trouble	☐	☐	Any Unusual Disease	☐	☐	Blood Disease	☐	☐	Stroke

If your mother, father or any of your brothers and/or sisters have died, what was the cause of their death and what was the age at the time of death?

____

____

____

I certify that the information provided above is true.

______________________ ______________________

Signature **Date**

Relationship: ___ Self

___ Parent or Legal Guardian

___ Other: ______________________

(Please Specify)

Physician Notes: ____

____

____

______________________ ______________________

Physician Signature **Date**

Patient Label

IRONMAN Sports Medicine Institute

MEMORIAL HERMANN

New Patient
Additional Information

Height ________ **Weight** ________ **Dominant Hand (circle):** Right Left

Is this a new condition? (circle) YES or NO

When did this problem begin? ___ days ___weeks ___months ___ years (Please indicate number)
Was this a result of an injury? (circle) YES or NO **If YES, when did the injury occur Date)?** __________
If yes, please explain how the injury occurred?

____

____

Is this a sports related injury? YES or NO **If so, what sport?** ____________________
Is this a work related injury? YES or NO **Is this a result of a motor vehicle accident?** YES or NO

Your pain is (circle all that apply):

Intermittent Constant Symptoms Increase with activity
Sharp Dull/Achy Stabbing Throbbing Burning

Symptoms are made worse by (circle all that apply):

Sitting Walking Lifting Twisting Lying on affected area Bending Squatting Kneeling
Going up stairs Going down stairs Coughing Sneezing

Symptoms are made better by (circle all that apply):

Rest Ice Heat Elevation Medication Physical Therapy Injections Brace Nothing helps

If medication, please indicate which one: ____________________

Pain Score (circle)

No pain 1 2 3 4 5 6 7 8 9 10 Maximum pain

Have you been seen by another physician for this problem? YES or NO **If YES, Doctor's name?**__________
Have you been seen in the Emergency Room for this problem? YES or NO **If YES, which one?**__________

Are there any questions you have for us today?

____

____

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

UT★Physicians

STATEMENT OF FINANCIAL RESPONSIBILITY

FINANCIAL RESPONSIBILITY

Thank you for choosing UT Physicians, as your healthcare provider. As courtesy, we are providing you with this Statement of Financial Responsibility and encourage you to ask questions regarding this statement.

In consideration for the services to be rendered to the Patient; the Patient and/or guarantor assumes full financial responsibility for the payment of the Patient's account.

Accurate insurance information and a copy of the insurance card(s) must be supplied by the Patient or guarantor. The Patient or the guarantor will be responsible for any co-payment, deductible and/or coinsurance deemed by the Patient's medical insurance plan, at the time services are rendered.

The Patient or guarantor will contact the medical insurance plan to determine what benefits and services provided are covered. The Patient or guarantor understands they are financially responsible to UT Physicians for all services whether or not a covered benefit. The Patient or guarantor is responsible for all balances on the account; in which their insurance has determined patient responsibility based on plan benefits. UT Physicians recommends the Patient or guarantor confirm UT Physicians practitioners are In-network providers for the Patient's medical insurance plan.

If the Patient and/or guarantor does not present proof of medical insurance, the patient will be deemed "self-pay" at time of service. A pre-determined minimum payment is required prior to services being rendered.

ASSIGNMENT OF BENEFITS

UT Physicians may submit requested medical information as required for payment to the Patient's insurance plan(s). Such medical information will include the diagnoses and treatments provided by UT Physicians.

STATEMENT OF FINANCIAL RESPONSIBILITY

Information provided by the patient and/or guarantor should be true and complete to the best of your knowledge. It is important for you to understand any financial responsibilities based on the terms of this document and have your questions fully answered.

UT★Physicians

MyUTP

Patient Portal Authorization Form

Our patient portal lets established patients communicate more easily with us. The portal is not intended for "Web Visits" or new problems. Instead, it will make regular communications more flexible. The portal is a voluntary option and is free of charge to all patients. The patient portal provides you with a more seamless way to access your health information and contact our office.

Through the portal, you can:

- Request refills, schedule appointments and ask for referrals.
- Update your contact and insurance information.
- Check your medication list, medical history and your visits.
- Get your lab results quickly.
- Email us securely back and forth.

We want your records to be complete and correct. Let us know if there's any problem with your records. Sometimes we may use medical jargon in your records and it can lead to confusion. If something doesn't make sense, let us know.

Privacy matters. We will never sell/trade/abuse your e-mail address. The patient portal is protected just like all other interactions with our office. We also think it's important for you to protect privacy on your end, and we recommend that you protect your user name and password to avoid misuse.

We take security seriously, too. Computer networks do have real risks. We use appropriate technologies to protect your health information. We follow all security laws, including HIPAA and HITECH.

Bedside manner is complicated via email. It's easy to misread information or emotion. We'll try to keep things brief and clear on the Portal. We really appreciate your help on that, too. If a message takes a long time to write, it's probably something better done in person at an office visit.

If we have troubles, abuse or "Spam", we may need to change policies, suspend accounts, or even terminate the portal.

You can access the portal day or night, but we don't have a 24 hour presence on our end. As a safeguard, the portal should not be used for pressing issues. If you are experiencing an emergency or have an urgent medical need, you should call our office. If it's after hours, we recommend that you go to Urgent Care, the Emergency Room or call 911.

______ INITIALS *I am signing up for the portal on behalf of ☐ Myself ☐ Parent ☐ Child ☐ Ward.*
I understand that the email address provided at the time of registration is the email address that will be associated with the MyUTP account and cannot be changed without written consent. There will be no portal access to anyone between the ages of 13-18 years of age because of medical record privacy concerns.

______ INITIALS *By signing below, I understand there are pros and cons to using the patient portal for communications with the clinic. I have had a chance to discuss my concerns with the office and have my questions answered.*

______ INITIALS *By signing below, I acknowledge that I would like a Patient Portal account and agree to the terms and conditions set forth above.*

Signature	Date	Relationship

Printed Name	Email Address

UT★Physicians

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

UT★Physicians

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.

PATIENT CONCERNS

Our entire staff strives to provide excellent care and service, and we hold ourselves to high 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 sincerely want to correct it. Usually, a word to your nurse is all that is needed, but if you prefer, call Patient Relations to speak confidentially with a patient representative. Your question or concern will be promptly addressed. We appreciate 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 OF EMAIL ADDRESS

You are requested to provide your email address to UT Physicians. The provision of your email address is entirely voluntary. Your email address may be used by UT Physicians, its affiliated entities, and business associates for the following purposes: appointment reminders, to inform you of benefits and services related to your health, through the use of online surveys emailed to you by UT 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) UT 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 UT 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.

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize UTP and the Patient's physician(s) to disclose the Patient's health care information to any person, Social Security Administration, insurance or benefit payer, health benefit plan, worker's compensation carrier or other entity specified in UTP's Joint Notice of Privacy Practices, and to the extent specified in said Notice, which is or may be liable for all or a portion of the treating physician's charges, and to complete claim forms on behalf of the Patient.

I understand that special written authorization from me (the Patient or legal guardian of the Patient) will be requested by UTP prior to releasing health care information if the Patient is receiving mental health services or care in an alcohol or drug treatment program or facility.

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 other than the rendition of services. All of my questions have been fully answered.

PATIENT/LEGAL GUARDIAN SIGNATURE **(Patients over 18 years of age)**	**DATE**
PRINT NAME **(If Legal Guardian, state relationship to patient)**	**PATIENT/LEGAL GUARDIAN EMAIL ADDRESS**

GUARANTOR/INSURED SIGNATURE	**DATE**
PRINT NAME	**RELATIONSHIP TO PATIENT**

WITNESS SIGNATURE	**DATE**
PRINT NAME	

UT★ Physicians

CONSENT FOR MEDICAL TREATMENT, DISCLOSURES, AND WAIVERS

CONSENT FOR MEDICAL CARE AND TREATMENT

Knowing that I or the individual for which I am a legal guardian (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 UTP and its staff to carry out the instructions of these physicians. Some physicians furnishing services to the Patient, including radiologists, pathologists, anesthesiologists, emergency room physicians and others are independent contractors, are not employees or agents of UTP, and may directly bill the Patient or other legally responsible person (Guarantor) signing this consent for services rendered.

FINANCIAL RESPONSIBILITY

In consideration for the services to be rendered to the Patient, the Patient and/or Guarantor signing this consent authorizes credit investigation and individually assumes full financial responsibility for the payment of the Patient's account in accordance with the regular rate and terms of UTP. If the account is referred to an attorney or collection agency, the same person agrees to pay actual attorney's fees and collection expenses. All delinquent accounts may bear interest at the legal rate.

IRREVOCABLE ASSIGNMENT OF INSURANCE BENEFITS

In consideration for services rendered, I hereby irrevocably assign and transfer to UTP for myself, my dependents and those for which I am financially responsible all rights, title and interest in the benefits payable for services rendered by UTP provided in any insurance policy(ies) under which I, any of my dependents or those for which I am financially responsible are insured. Said irrevocable assignment and transfer shall be for the purpose of granting UTP an independent right of recovery in any policy(ies) of insurance to which benefits may be payable for services rendered, but shall not be construed to be an obligation of UTP to pursue any such rights or recovery. I herby authorize and direct all insurance company(ies) under which I, any of my dependents or those for which I am financially responsible are insured to pay directly to UTP all benefits due under said policy(ies) by reason of services rendered therein. I will pay UTP for all charges incurred, or alternately, for all charges in excess of the sums actually paid by said policy(ies). I also irrevocably assign to UTP all rights, title and interest in benefits payable out of any third party action against any other person, entity, or insurance company, or out of recovery under the uninsured motorist provisions or the medical payment provisions of any automobile insurance policy(ies) or any other insurance policy(ies) under which the Patient may be entitled to recover.

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 are responsible for the Patient's financial obligations. 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.).

UT Physicians

A Part of UTHealth

Permission for Verbal Communications

Name:______________________ Birth:______________________

Address:______________________ City,State,Zip Code______________________

Phone:______________________

I permit UT Physicians, their physicians, nurses, and other personnel ("Health Care Providers") to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care: (list family members/friends and state the person's relationship to the patient):

This authorization is limited to discussion regarding the following medical condition(s):

____

(If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care.)

Name	Phone Number	Relationship
1.		
2.		

Release of information under this document is limited to verbal discussion with my Health Care Providers. This document does not permit release of any written health information to the individuals named above.

This authorizations is limited to the following timeframe from__________(date)__________(date).

If no dates are indicated, this form will remain in effect for an unlimited amount of time.

If at any time, I do not want verbal discussions to be permitted between my Health Care Providers and any of the individuals named above, I must notify my Health Care Provider by contacting the UT Physicians Health Information Department.

Patient's Signature:______________________ Date:______________________

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

Representative's Name:______________________

Relationship to patient:______________________

Instructions: Please print, sign and send to: UT Physicians-Health Information Management 6410 Fannin Suite 6410 Suite LL100 Houston, Texas 77030 Phone: 832-325-6543

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 intercambio 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:

UT★Physicians

A Part of UTHealth

(Label Here)

Preferred Pharmacy:______________________________

Pharmacy phone number: ______________________________

Pharmacy cross streets: ______________________________

Memorial City Ironman
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