ALAMO
Family Practice

CONSENT FOR TREATMENT

1. I consent to any treatment, test or procedure ordered by and given under the supervision of a physician.

2. I acknowledge that no guarantees have been made to me as to the results of the medical treatment hereby authorized.

3. Texas law permits the disclosure of patient health information without authorizations in certain specific settings, including disclosure for payment purposes, for continuing care, and to an organ procurement organization.

4. I acknowledge that I have been given a copy of the Patient Rights and Responsibilities for my personal use.

5. I acknowledge that I have been given a copy of Notice of Privacy Practices for my personal use.

6. The physician's office has my consent to leave phone messages at my home or on my personal voice mail.

7. I acknowledge that Alamo Family Practice uses E-Prescribing to facilitate medical management for the patient and the patient's medication history will be uploaded through RX HUB.

Signature_____ Date_____

Name_____ Witness_____