Greater Houston OB/GYN, L.L.P.
Memorial Hermann Tower
929 Gessner, Suite 2150
Houston, TX 77024-2414
Tel: (713) 935-9791
Fax: (713) 467-9709

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Name of Patient:_____ **Date of Birth:**____/____/____

Address:_____ **City:**_____ **State:**_____ **Zip:**_____

Phone: (_____)_____ **Email Address (Optional)**_____

I hereby authorize: **Greater Houston OB/GYN, L.L.P.**
929 Gessner Rd., Suite 2150
Houston, TX 77024

☐ Dr. Carol M. Storey ☐ Dr. Sharon S. McCloskey
☐ Dr. Camille V. Boon ☐ Dr. Ashley E. Hester
☐ Dr. Anne V. Gonzalez

☐ To Disclose to ☐ To Receive from

Person/Organization Name:_____ Phone:(_____)_____
Address:_____ City:_____ State:_____ Zip:_____

Records are requested for the purpose of:
☐ Continuing Care/Medical Facility ☐ Personal Use
☐ Legal ☐ Insurance
☐ Other:_____

Specific information to be released (check all that apply):

____ **All Health Information**	____ Physician's Orders	____ Progress Notes	____ Pathology Reports
____Discharge Summary	____ History/Physical Exam	____ Patient Allergies	____ Past/Present Medications
____Operative Reports	____ Diagnostic Test Reports	____ Radiology Reports	____ Lab Results
____Consultation Reports	____ EKG/Cardiology Reports	____ Billing Information	____ Other_____

Your initials are required to release the following information:

_____ Mental Health Records (excluding psychotherapy notes) _____ Genetic Information (including test results)
_____ Drug, Alcohol, or Substance Abuse Records _____ HIV/AIDS Test Results/Treatment

I understand that this Authorization is effective for a period of 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized to release the information. If applicable, specify other expiration date/event here:____/____/____

SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provides by Texas Health & Safety Code § 181.154 (c) and/or 45 C.F.R. § 164.502 (a) (1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws. I also understand I am signing this authorization voluntarily and treatment, payment, or my eligibility for benefits will not be affected if I do not sign this authorization.

_____ _____ ____/____/____
Signature of Patient or Patient's Legally Authorized Representative | Printed Name of Patient or Patient's Legally Authorized Representative | Date

PATIENT REGISTRATION

First Name _____ Middle _____ Last _____

Home Address _____ Apt. # _____

City _____ State ____ Zip _____ Sex _____ Date of Birth _____

Phone (Home) _____ Cell _____ Work _____

Referred By: _____ Marital Status: ____S____M____W____D

EMPLOYMENT: ____ Student ____ Retired ____Unemployed ____ Self-Employed ____ Employed

Employer _____ Occupation _____

Your Email: _____

Spouse's Name: _____ Phone # _____

Emergency Contact: _____ Phone # _____

INSURANCE INFORMATION / RESPONSIBLE PARTY

Primary
Insurance Company _____ Phone # _____

Policy # _____ Group # _____

Card Holder's
First Name _____ Middle _____ Last _____

Date of Birth _____ Sex _____

Relationship to Patient _____ Self _____ Spouse _____ Parent _____

Employer _____ Phone # _____

Secondary Insurance _____ Phone # _____

Policy # _____ Group # _____

Card Holder's
First Name _____ Middle _____ Last _____

Date of Birth _____ Sex _____

Relationship to Patient _____ Self _____ Spouse _____ Parent _____

Employer _____ Phone: _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN: I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non covered services.

_____ _____
Signature Date

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

_____ _____
Signature Date

Greater Houston Ob/Gyn LLP

Patient Medical History Form

Name_____ DOB_____ Today's Date_____

☐ Single ☐ Married ☐ Separated ☐ Widowed Referred By:_____

Pharmacy Name:_____ Pharmacy Tel. #_____

Medical History Have you ever had any of the following?

- ☐ Anemia
- ☐ Heart Disease/Attack
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ High Cholesterol
- ☐ Mitral Valve Prolapse
- ☐ Bleeding Problems
- ☐ Breast Cancer
- ☐ Blood Clots in Lungs/Legs
- ☐ Gall Bladder Disease
- ☐ Liver Disease/Hepatitis
- ☐ Kidney Infections
- ☐ Bladder Infections
- ☐ Pelvic Infections
- ☐ Arthritis
- ☐ Ovarian Cancer
- ☐ Ovarian Cyst
- ☐ Chicken Pox
- ☐ Epilepsy/Seizures
- ☐ Migraines
- ☐ Depression/Anxiety
- ☐ Drug or Alcohol Problem
- ☐ Diabetes
- ☐ Colon Cancer
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Sickle Cell Disease
- ☐ Thyroid Problem
- ☐ Blood Transfusion
- ☐ Genetic Condition
- ☐ Asthma
- ☐ Other Cancer

List all medications & **dose** you are currently taking, including over-the-counter medications, vitamins and herbal remedies:

_____ _____ _____

_____ _____ _____

List any allergies to medications_____ ☐ No Known Allergies

Reaction:_____

Surgical History

Date	Surgery

Obstetrical History

☐ Check here if you have never been pregnant ☐ Check here if you have adopted children

Please list all pregnancies in order, including miscarriages, premature births, stillbirths, ectopics (tubal) and abortions:

Year	M/F	Infant's Weight	Type of Delivery	Gestational Age at delivery	Delivering Doctor	Problems

Name_____ DOB_____ Today's Date_____

Gyn History

Last Mestrual Period:_____ Age of first period_____

Cycle Length: every_____days Lasting? ☐ 1-3 days ☐ 4-6 days ☐ 7-9 days

Periods are: ☐ Regular ☐ Irregular ☐ Painful (Cramping/aching) ☐ Not really bothersome

Flow is: ☐ Light ☐ Light to moderate ☐ Moderate to heavy ☐ Very heavy

☐ Menopause Age:_____ ☐ Hysterectomy Type/Date:_____

Are you sexually active? ☐ Yes ☐ No ☐ Virginal

Recent New partners? ☐ Yes ☐ No

Number of lifetime partners_____

Sexual Preference: ☐ Male ☐ Female ☐ Both

Birth Control Method: ☐ condoms ☐ pills ☐ patch ☐ vaginal ring ☐ tubal/Essure ☐ natural family planning ☐ partner with vasectomy ☐ IUD type_____ year inserted_____ ☐ Other ☐ None

Have you ever had any of the following STD's? ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ HPV ☐ Syphilis ☐ Trichomonas ☐ HIV ☐ Hepatitis B ☐ Hepatitis C ☐ None

Have you ever received Gardasil (HPV) Vaccine? ☐ Yes ☐ No

If Yes, Date:_____ Received all three doses?_____

Have you ever had any of the following? ☐ Fibrocystic breasts ☐ Ovarian Cysts ☐ Endometriosis ☐ Uterine Fibroids

Date of last pap smear_____ ☐ Normal ☐ Abnormal

Have you ever needed any of the following for an abnormal pap? ☐ Colposcopy ☐ Cryosurgery ☐ Leep/Laser/Conization ☐ None

Date of last mammogram_____ ☐ Normal ☐ Abnormal ☐ Never had one

Date of last bone density_____ ☐ Normal ☐ Osteopenia ☐ Osteoporosis ☐ Never had one

Date of last colonoscopy_____ ☐ Never had one

Family History

Please list any close relatives with history of the following:

☐ Breast Cancer_____

☐ Ovarian Cancer_____

☐ Colon Cancer_____

☐ Uterine Cancer_____

☐ Other_____

Please list Relationship/Age at Diagnosis/Status

☐ High blood pressure_____

☐ Diabetes_____

☐ Heart Disease (heart attack, stroke, bypass surgery)_____

Name_____ DOB_____ Today's Date_____

Social History

Alcohol use	☐ Yes	☐ No	If yes,_____drink(s) per day/week/month					
Tobacco use	☐ Yes	☐ No	If yes,_____pack(s) per day for_____years					
Street drug use	☐ Yes	☐ No	Type and frequency_____					
Exercise	☐ Yes	☐ No	Type and frequency_____					
Caffeine	☐ Yes	☐ No	If yes,_____caffeinated drink (coffee, tea, soda) per day/week					
Sexual Abuse	☐ Yes	☐ No	If yes, are you safe now?	☐ Yes	☐ No	Counseling	☐ Yes	☐ No
Physical Abuse	☐ Yes	☐ No	If yes, are you safe now?	☐ Yes	☐ No	Counseling	☐ Yes	☐ No
Emotional Abuse	☐ Yes	☐ No	If yes, are you safe now?	☐ Yes	☐ No	Counseling	☐ Yes	☐ No

Patient Signature_____ Date:_____

Greater Houston OB/GYN, L.L.P.

Michele Storey, M.D.
Ashley Hester, M.D.
Anne Gonzalez, M.D.

Sharon S. McCloskey, M.D.
Camille V. Boon, M.D.

FINANCIAL POLICY

Thank you for choosing us as your health care provider. In order to serve you better, we require that all patients read and sign our financial policy. It is your responsibility to understand whether your provider is In-Network to maximize your benefits. We will be glad to assist you with any questions you may have.

1. Your insurance card must be presented at each visit. It is your responsibility to provide us with ALL the correct information to ensure proper billing to your insurance company. We will require a patient information sheet to be filled out once a year.
2. We will collect your co-payment, deductible, coinsurance, or charges for noncovered services **at the time of your visit**. If you have a balance from a previous visit, we will also ask for that payment. We accept cash, checks and all major credit cards. **Returned checks or stop payments will incur a service charge, currently $30.00.**
3. Surgery and Maternity patients: We will verify your benefits with your insurance company and inform you of any deposit due such as unmet deductible or coinsurance. Surgery deposits are due at least 5 days prior to surgery. Maternity patients will be given a payment plan to be **Paid in Full** before the seventh month of pregnancy.
4. Discounts such as professional courtesy, filing insurance only, waiving copayment, coinsurance or deductible are expressly forbidden by the managed care contracts our office has signed.
5. Medicare Patients: As a participating provider, we will file your Medicare claim for you. If you have a supplemental policy, we will also bill that for you. Each year you will be expected to pay the allowed amount of your charges until your Medicare annual deductible has been met. You are responsible for any noncovered services.
6. Self-Pay Patients: Without medical coverage, payment is expected **at the time of service**. If you are unable to pay in full, you **must** contact our billing office prior to your appointment to make payment arrangements.
7. Disability and health forms are completed for a fee of $20.00 per form and must be paid when presented. We will require at least 14 business days to prepare your forms.
8. Any unpaid accounts are reported to the credit bureau after 90 days. If reported, the fact that you received treatment at our office may become a matter of public record.

I certify that the insurance information I have provided is correct. I agree to pay in full for services upon notification that these charges have not been paid and are my responsibility. Any patient balance unpaid after ninety (90) days will be reported to the credit bureau and the patient will be released from the practice for nonpayment. The unpaid balance will be referred to a collection agency. We reserve the right to change our financial policy at any time.

Patient's Signature:_____ **Date:**_____

Patient's Name:_____

Parent or Legal Guardian:_____ **Date:** _____

HIPAA Notice of Privacy Practices

Greater Houston OB/GYN, LLP
929 Gessner Rd, Suite 2150
Houston, Texas 77024
(713) 935-9791

Michele Storey, M.D.
Ashley Hester, M.D.
Anne Gonzalez, M.D.
Sharon S. McCloskey, M.D.
Camille V. Boon, M.D.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1.Uses and Disclosures of Protected Health Information
Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Worker' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information: Under federal law, however, you may not inspect or copy the following records: psychotherapy note; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information: This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e., electronically.

You may have the right to have your physician amend your protected health information: If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Your have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints: You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of your legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices;

Print Name: _____

Signature: _____

Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Greater Houston OB/GYN, LLP
929 Gessner Rd, Ste 2150
Houston, Texas 77024
(713) 935-9791

Michele Storey, M.D.
Ashley Hester, M.D.
Anne Gonzalez, M.D.

Sharon S. McCloskey, M.D.
Camille V. Boon, M.D.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

I give my permission to release information regarding test results and to discuss any treatment for my care received in your office. I additionally request that this person or persons have the availability to discuss any billing issues for the treatment that I have received.

Name or names: _____

_____

Patient Name (please print): _____ Today's Date: _____/_____/_____

Signature: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reasons:

Patient Portal Authorization Form

Purpose of this Form:
The Patient Portal is designed to improve physician and patient communication. Once you are registered as a patient and have provided us with your secure email you will be assigned a username and password. After you registered with the Patient Portal you will be allowed the following:

- Update your contact information
- Request your own appointments
- Communication of laboratory results from staff to patient
- Request prescription refills
- View your medical summary, medication list, treatment history and visitation dates
- Receive reminders through your email

The following will **NOT** be accepted through Patient Portal:

- Request for narcotics/controlled medications.

Online communications should never be used for life threatening, emergency communications or urgent requests. If you have an emergency or an urgent request, you should contact 911 or your physician via telephone.

Reminders for Patient Portal:

- You will have 3 failed log in attempts before the account is locked
- You will be receiving reminders via email from reminders@eclinicalmail.com regarding your appointments, test results posting etc. Please make security adjustments to your email or computer to receive our emails.
- You will not be able to reply to our email reminders from reminders@eclinicalmail.com. If you have any questions regarding these emails please send us a message via Patient Portal.
- If you forget your password you may request another one through Patient Portal by clicking on the "Forgot Password" link.
- After you are finished accessing Patient Portal be sure to logout and close your browser. This reduces the risk of someone else accessing your private information.
- Avoid using a public computer to access Patient Portal.
- Patient Portal is provided as a courtesy service for our patients. There is no service fee. However if the patient abuses or misuses Patient Portal we reserve the right to terminate the patient's account.
- Our hours of operation are 8:00 am - 5:00 pm Monday-Thursday and 8:00-12 noon on Friday. We encourage you to use the web site at any time; however messages are held for us until we return the next business day. Messages are typically handled within 2 business days. If your doctor is out of the office, your request may be held until your doctor returns to the office.
- We reserve the right to suspend or terminate the patient portal at any time and for any reason.

How the Secure Patient Portal Works:
A secure web portal is a type of webpage that uses encryption to keep unauthorized persons from reading communications, information, or attachments. Secure messages and information can only be read by someone who knows the right password or pass-phrase to log in to the portal site. Because the connection channel between your computer and the website uses secure sockets layer technology you can read or view information on your computer, but it is still encrypted in transmission between the website and your computer.

Patient Portal Authorization Form

Protecting Your Private Health Information and Risks:
This method of communication and viewing prevents unauthorized parties from being able to access or read messages while they are in transmission. No transmission system is perfect. We will do our best to maintain electronic security. However, keeping messages secure depends on two additional factors:
1) The secure message must reach the correct email address, and
2) Only the correct individual (or someone authorized by that individual) must be able to have access to the message.

Only you can make sure these two factors are present. **It is imperative that our practice has your correct e-mail address and that you inform us of any changes to your e-mail address.**
You also need to keep track of who has access to your email account so that only you, or someone you authorize, can see the messages you receive from us. You are responsible for protecting yourself from unauthorized individuals learning your password. If you think someone has learned your password, you should promptly go to the website and change it.
Patient Acknowledgement and Agreement:
I acknowledge that I have read and fully understand this consent form and the Policies and Procedures regarding the Patient Portal that appears at log in. I understand the risks associated with online communications between my physician and me, and consent to the conditions outlined herein. In addition, I agree to follow the instructions set forth herein, including the Policies and Procedures set forth in the log in screen, as well as any other instructions that my physician may impose to communicate with patients via online communications. I understand and agree with the information that I have been provided.

Secure Email Address: _____

Printed patient name: _____ DOB: _____

Patient Signature: _____ Date: _____

Complete the following if the email address does not belong to the patient: Please note, portal access is not available for patients under the age of 18.

Name of Parent/Guardian requesting access:

_____

Relationship to the Patient: _____

Our Patient Portal site may be accessed by two different URL's.
Our Website: www.greaterhoustonobgyn.com
Patient Portal direct site: https://mycw35.eclinicalweb.com/portal3834/jsp/100mp/login_otp.jsp

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:

MHiE
Memorial Hermann
Information Exchange