

I understand that, under the Health Insurance Portability & Accountability Act of 1996, as amended and supplemented (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). PHI may originate in your medical record at UANT, an affiliate of USMD Affiliated Services, or may be received from outside health entities and filed in your medical record.

I understand that this information can and will be used by UANT, an affiliate of USMD Affiliated Services, to: (a) Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly, (b) Obtain payment from third-party payers, (c) Conduct normal healthcare operations such as quality assessments and physician certifications, (d) Notification of educational events specific to my medical condition through UANT, an affiliate of USMD Affiliated Services, or networking organizations, (e) Consent to property transfer of specimen (tissue obtained during a medical test) to UANT, an affiliate of USMD Affiliated Services, and (f) Any such other purposes permitted under HIPAA.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that UANT, an affiliate of USMD Affiliated Services, has the right to change its Notice of Privacy Practices from time to time and that I may obtain a current copy of the Notice of Privacy Practices from my local office or by contacting the Privacy Officer at 900 Airport Freeway, Suite 158, Hurst, TX 76054.

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. I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

I prefer to be contacted in the following manner:

Primary Phone#: () _____ Secondary Phone#: () _____

- | | |
|---|---|
| <input type="checkbox"/> Leave message with contact number only. | <input type="checkbox"/> Leave message with contact number only. |
| <input type="checkbox"/> Leave message with detailed information. | <input type="checkbox"/> Leave message with detailed information. |
| <input type="checkbox"/> Do not leave message. | <input type="checkbox"/> Do not leave message. |

I prefer to receive reminders regarding upcoming appointments in the following manner:

- Leave message.
 Decline/Do Not Call.

I prefer to receive a summary of my office visit in the following manner:

- Printed.
 Decline.
 Follow My Health Patient Portal (sign up required for access).

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Relationship to Patient