Patient Label (Name, DOB, MRN)

Texas Tech University Health Sciences Center
Ambulatory Clinics

CONSENT TO TREATMENT:

I voluntarily consent to receive medical and health care services provided by TTUHSC physicians, employees and such associates, assistants, and other health care providers, as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand that TTUHSC is a teaching institution and I agree to be a part of the teaching programs. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I understand that this consent to treatment will be valid and remain in effect as long as I attend the TTUHSC Ambulatory Clinics unless revoked by me in writing with such written notice provided to each clinic attended by me.

CONSENT TO DISCLOSURE OF PROTECTED HEALTH INFORMATION: Your protected health information pertains to your diagnosis and/or treatment at TTUHSC, including but not limited to information concerning mental illness (except for psychotherapy notes), use of alcohol or drugs or communicable diseases such as Human Immunodeficiency Virus ("HIV") and Acquired Immune Deficiency Syndrome ("AIDS"), laboratory test results, medical history, treatment progress or any other such related information.

By signing this form, you consent to TTUHSC's use and/or disclosure of protected health information about you for treatment, payment, health care operations and as otherwise allowed by law. Our Notice of Privacy Practices provides information about how TTUHSC and its workforce may use and/or disclose protected health information about you for treatment, payment, health care operations and as otherwise allowed by law.

> **RELEASE FROM LIABILITY:** I release and agree to hold harmless TTUHSC and its agents, representatives, and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization. I understand TTUHSC cannot be responsible for use or redisclosure of information by third parties.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me to TTUHSC physicians and/or Medical Practice Income Plan. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and heath care charges, to TTUHSC physicians and/or Medical Practice Income Plan. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct.

I agree to pay all charges for medical and health care services not covered by or which exceed the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer and agree to make payment as requested by TTUHSC.

I certify that this form has been fully explained to me, that I have read it or had it read to me*, and that I understand its contents.

ADVANCE DIRECTIVE:
I have signed an Advance Directive. ____ YES ____ NO;
If yes, is it still in effect? ____YES _____ NO; I have provided a signed copy to TTUHSC. _____ YES _____ NO

NOTICE OF PRIVACY PRACTICES:
I have received a paper copy of TTUHSC's Notice of Privacy Practices. _____
(Patient's Initials)

_____	_____	_____
Date	Time	Patient/Other legally authorized person
_____	_____	_____
Witness*	Print Name	Print name and relationship to patient