DAVE E. WEBSTER D.O., PA.
FAMILY MEDICINE / URGENT CARE
5610 E. Central Texas Expressway., Suite 1
Killeen, TX 76543 Phone: (254) 690-8887

# CONSENT FOR MEDICAL TREATMENT

I HEREBY GIVE CONSENT TO DR. DAVE E. WEBSTER, TO ADMINISTER SUCH IMMUNIZATIONS, DIAGNOSTIC, OR THERAPEUTIC TREATMENT OF ILLNESSES AND/OR INJURIES, AND FOR MINOR OPERATIVE PROCEDURES AS DEEMED NECESSARY FOR ME, BY A MEDICAL PRACTITIONER, AND TO REFER ME TO OTHERS AS APPROPRIATE.

_____ _____
**NAME OF PATIENT (PLEASE PRINT)** **DATE**

_____ _____
**SIGNATURE OF PATIENT OR GUARDIAN** **SOCIAL SECURITY #**

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**NOTICE OF HEALTH INFORMATION PRACTICES**
**ACKNOWLEDGEMENT FORM**

## DAVE E. WEBSTER, D.O., PA

THE ATTACHED NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE SIGN THIS COVER SHEET ACKNOWLEDGING RECEIPT OF THE POLICY AND RETURN IT TO THE RECEPTIONIST. REVIEW THE POLICY CAREFULLY AND LET US KNOW IF YOU HAVE ANY QUESTIONS OR REQUESTS.

BY MY SIGNATURE BELOW, I ACKNOWLEDGE THAT I HAVE RECEIVED THE NOTICE OF HEALTH INFORMATION PRACTICES OF DAVE E. WEBSTER, D.O.

I UNDERSTAND THAT THE ORGANIZATION RESERVES THE RIGHT TO CHANGE THEIR NOTICES AND PRACTICES AND PRIOR TO IMPLEMENTATION WILL MAIL A COPY OF ANY REVISED NOTICE TO THE ADDRESS I HAVE PROVIDED. I UNDERSTAND THAT I HAVE THE RIGHT TO REQUEST RESTRICTIONS AS TO HOW MY HEALTH INFORMATION MAY BE USED OR DISCLOSED AND THAT THE ORGANIZATION IS NOT REQUIRED TO AGREE TO THE RESTRICTIONS REQUESTED. I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING, EXCEPT TO THE EXTENT THAT THE ORGANIZATION HAS ALREADY TAKEN ACTION IN RELIANCE THEREON.

_____
**NAME OF PATIENT (PLEASE PRINT)**

_____ _____
**SIGNATURE OF PATIENT OR GUARDIAN** **DATE**

**AUTHORIZATION TO DISCLOSE HEALTH INFORMATION**

# DAVE E. WEBSTER, D.O., PA

5610 E. CENTRAL TEXAS EXPRESSWAY, SUITE 1
KILLEEN, TX 76543 Phone: (254) 690-8887

_____ _____

**PATIENT NAME** **DATE OF BIRTH**

BY MY SIGNATURE BELOW, I AUTHORIZE THE USE OR DISCLOSURE OF MY INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION AS DESCRIBED BELOW. I UNDERSTAND THAT IF THE ORGANIZATION AUTHORIZED TO RECEIVE THE INFORMATION IS NOT A HEALTH PLAN OF HEALTH CARE PROVIDER; THE RELEASED INFORMATION MAY NO LONGER BE PROTECTED BY FEDERAL PRIVACY REGULATIONS.

**PLEASE PROVIDE NAMES OF PERSONS OR ORGANIZATIONS TO WHOM WE MAY DISCLOSE INFORMATION**

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THE PATIENT OR THE PATIENT'S REPRESENTATIVE MUST READ AND INITIAL THE FOLLOWING STATEMENTS:

1. I UNDERSTAND THAT THIS AUTHORIZATION WILL EXPIRE ON ___/___/___(DD/MM/YY). IF I FAIL TO SPECIFY AN EXPIRATION DATE, THIS AUTHORIZATION WILL EXPIRE IN SIX MONTHS.
2. I UNDERSTAND THAT I MAY REVOKE THIS AUTHORIZATION AT ANY TIME BY NOTIFYING THE PROVIDING ORGANIZATION IN WRITING. I UNDERSTAND THAT THE REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION AND WILL NOT APPLY TO MY INSURANCE COMPANY WHEN THE LAW PROVIDES MY INSURER WITH THE RIGHT TO CONTEST A CLAIM UNDER MY POLICY.
3. I UNDERSTAND THAT MY HEALTHCARE AND THE PAYMENT FOR MY HEALTHCARE WILL NOT BE AFFECTED IF I DO NOT SIGN THIS FORM.
4. I UNDERSTAND THAT I MAY SEE AND COPY THE INFORMATION DESCRIBED ON THIS FORM AND WILL RECEIVE A COPY OF THIS FORM AFTER IT IS SIGNED.
5. IF I HAVE QUESTIONS ABOUT DISCLOSURE OF MY HEALTH INFORMATION, I CAN CONTACT THE OFFICE STAFF OR THE PHYSICIAN.

_____ _____

**SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE** **DATE**

_____

**RELATIONSHIP TO PATIENT**