Dr.Anand Balasubramanian MD PA
Primary care & internal medicine
205 Hollow tree Houston TX 77090
P: 281-893-8100 F: 281-271-8457

PATIENT CONSENT FORM

I understand that, under the health insurance portability & Accountability of act of 1996 (HIPAA), 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 the treatment directly and indirectly.
- Obtain payment from third –part payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

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 have been given the right to review such notice of privacy practices prior to signing the consent. 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 below to obtain a current copy of the notice of privacy 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.

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.

Patient Name (Print): _____

Signature: _____

Relationship to patient _____ Date: _____

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Patient General Consent to Treat

Patient Name: _____ DOB _____

I, the undersigned, hereby consent to the following

- Administration and performance of general treatments
- Use or prescribed medications
- Performance of diagnostic procedures/test and cultures
- Performance of other medically accepted laboratory test that may considered medically necessary of advisable based on the judgment of my physician or their assigned designees.

I fully understand that this consent is given in advance of any specific diagnosis or treatment.

I intend that this consent is continuing in nature even after specific diagnosis has been made and treatment recommended. This consent will remain in full force until revoked in writing.

A photocopy of this consent shall be considered as valid as the original.

I acknowledge that I have been given a copy of the notice of privacy practices. I understand that if I have questions or complaint that I should contact **281-893-8100 or Email: qa@ehealthmso.com**

Patient Signature (Print):_____

Patient Signature: _____

Date: _____