

# GEORGETOWN MEDICAL CLINIC



## PATIENT CONSENT FORM

### USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent to allow Georgetown Medical Clinic to use and disclose my Protected Health Information in order to carry out medical treatment, payment and healthcare operations.

#### Authorization/Insurance Payment

- I authorize Georgetown Medical Clinic to provide medical information to my insurance carrier and I authorize payment of insurance benefits to the Georgetown Medical Clinic for services provided to me.

#### Authorization to Leave Voice Messages and/or Email

- I authorize Georgetown Medical Clinic to leave messages by voice or email at my home or employment reminding me of scheduled medical appointments and other medical services for myself and/or my family members. I understand, however, that no message will be left regarding confidential medical information unless specifically authorized by my doctor and myself.

By signing this form, I am consenting to Georgetown Medical Clinic's use and disclosure of my protected medical information as detailed above. However, I may give notice to restrict the use of such information and revoke my consent in writing. I understand that I have the right to review the Notice of Privacy Practices for a more complete description of such uses and disclosures prior to signing this consent.

### RECORDS REVIEW FOR RESEARCH

- I also authorize Georgetown Medical Clinic and San Gabriel Clinical Research to review my records to determine my qualifications for approved clinical studies and to contact me if I have potential as a research candidate. No records are ever provided to other persons for research purposes, except by specific written approval from me.

### FINANCIAL RESPONSIBILITY

- I accept financial responsibility for all charges for medical care provided to me and/or my family members by the physicians and medical staff of this clinic.

### CONSENT TO TREATMENT BY PHYSICIAN ASSISTANT OR NURSE PRACTITIONER\*

- I agree to be treated by the Physician Assistant, (P.A.-C) a healthcare professional licensed by the Texas State Board of Medical Examiners. A Physician Assistant is incorporated by Georgetown Medical Clinic to provide an additional level of access to high quality patient care.
- I understand that I may change this decision at any time by requesting to see a physician, at which time the Clinic will assist me in scheduling my care.

\*If you would like additional information about Physician Assistant or Nurse Practitioner services and training, please ask the receptionist.

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Signature of Patient or Legal Guardian

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian