Mark D.Le M.D.,P.A.
Medical Clinic

602B Lawrence Street Tomball, TX 77375
Tel: (281) 255-6333 Fax: (281) 255-6335

846 11th Street Hempstead, TX 77445
Tel: (979) 921-0647 Fax: (979) 921-0245

CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPTIONS

I, _____ (patient name), understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the
- competence of healthcare professionals.

I understand and have been provided with Mark D. Le M.D.,P.A. Notice of Privacy Practices that provides a more complete description of my health information uses and disclosures. I understand that I have the right to review the notice prior to signing the consent. I understand that the organization reserves the right to change its notice 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 to carry out treatment, payment, or healthcare operations 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.

In addition to disclosure for treatment, payment and healthcare operations, the following individual(s) is/are allowed access to my personal health information *(please indicate relationship to you):*

_____

Name Relationship

_____

Name Relationship

Please circle one: I fully understand and **ACCEPT / DECLINE** the terms of this consent.

Signature of Patient/Legal Representative		
_____	_____	_____
Signature	Date	Relationship to the Patient