CONSENT TO TREAT
I (the patient/guardian/or legal representative to the patient, acting on the patient's behalf) give permission for medical treatment, including radiological and laboratory procedures, to be performed by the physicians, nurse practitioners, physician's assistants, and staff of HIGH PLAINS PRIMARY CARE.
Initials _____

PHARMACY/MEDICATION HISTORY
I authorize HIGH PLAINS PRIMARY CARE to obtain all my medication history, in any format, to provide my medical care. This consent is valid from this date forward. **Initials _____**

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES
I have reviewed HIGH PLAINS PRIMARY CARE's Notice of Privacy Practices, which explains how my medical information may be used and disclosed. I understand that I am entitled to receive a copy of this document if requested. **Initials _____**

ADVANCE DIRECTIVE LIVING WILL
Do you have an Advance Directive/living will? _____ Yes _____ No
If you answered no, would you like more information on Advance Directives? _____ Yes _____ No

PATIENT RECORDS OF DISCLOSURES
In general, the HIPAA (Health Insurance Portability and Accountability Act) privacy rule gives individuals the right to request a restriction on uses and disclosures of their PHI (Protected Health Information). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's residence.
Initials **_____**

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (PLEASE MARK EACH SECTION THAT APPLIES):

□ Home Telephone: _____
- □ Leave a message with detailed information
- □ Leave a message with call back number ONLY
- □ Please DO NOT leave a message

□ Work Telephone: _____
- □ Leave a message with detailed information
- □ Leave a message with call back number ONLY
- □ Please DO NOT leave a message

□ Mobile Telephone: _____
- □ Leave a message with detailed information
- □ Leave a message with call back number ONLY
- □ Please DO NOT leave a message

□ Fax Number: _____
- □ Please do not fax any information to me

□ Written Communication:
- □ Mail to my home address
- □ Mail to alternate address: _____
- □ Please DO NOT mail

□ The following people may have access to my medical information:
- □ Name & Relationship: _____
- □ Name & Relationship: _____
- □ Name & Relationship: _____
- □ Nobody should have access to my information

ADDITIONAL CONSENT REGARDING SERVICES PERFORMED IN TEXAS
I understand that the physician and other clinical staff employed by HIGH PLAINS PRIMARY CARE are licensed by the State of Texas and that the medical services provided to me by HIGH PLAINS PRIMARY CARE and its affiliated healthcare providers will be rendered in Texas. As such, I agree that the relationship between myself and HIGH PLAINS PRIMARY CARE (inclusive of its affiliated physicians and other healthcare providers) for care provided in Texas, will be governed by Texas laws without regard for conflicts of the laws principles. I also agree that any lawsuit or other dispute arising from or related to medical care I receive from HIGH PLAINS PRIMARY CARE and/or its affiliated physicians or other healthcare providers will be brought only in an appropriate court located in Lubbock County, Texas. This authorized information will apply to all HIGH PLAINS PRIMARY CARE providers and remains in effect until additional notice or changes are made by me, the patient. **Initials _____**

Relationship to Patient: □ Self □ Child □ Dependent □ Other: _____

_____	_____	_____
Patient Name *(printed)*	**Patient/Guardian/Legal Representative Signature**	**Date**
_____	_____	_____
Witness Name *(printed)*	**Witness Signature**	**Date**