

**Texas Tech University Health Sciences Center
Ambulatory Clinics**

Patient Name/Medical Record#

CONSENT TO TREATMENT: I voluntarily consent to receive medical and health care services provided by TTUHSC physicians, employees and such associates, assistants, and other health care providers, as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment. I understand that TTUHSC is a teaching institution and I agree to be a part of the teaching programs. I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I understand that this consent to treatment will be valid and remain in effect as long as I attend the TTUHSC Ambulatory Clinics unless revoked by me in writing with such written notice provided to each clinic attended by me.

RELEASE OF INFORMATION: TTUHSC may disclose all or any part of my medical record (including oral information) and may provide bills/invoices to: 1) any person, corporation or agency (or their authorized representative) which is or may be liable under a contract to TTUHSC, or to me or my family members for all or part of the clinic charges including, but not limited to, hospital or medical service companies, insurance or third-party payers, workers' compensation carriers, or my employer; and 2) any individual or entity designated by me as a guarantor or party responsible for payment of fees for health care services provided to me.

I understand and agree that the information I am authorizing to be released may include 1) AIDS/HIV test results, diagnosis, treatment and related information; 2) information about drug and alcohol use and treatment; and 3) mental health information.

I understand that I may revoke this authorization for the release of information at any time, by providing written notice to the Ambulatory Clinics, except to the extent that action has been taken in reliance on it. Unless earlier revoked, this authorization expires automatically ninety (90) days from the date signed or ninety (90) days after the last clinic visit or after all insurance or third party claims have been paid or satisfactorily resolved, whichever occurs last.

RELEASE FROM LIABILITY: I release and agree to hold harmless TTUHSC and its agents, representatives, and employees from any and all liability associated with the release of confidential patient information in accordance with this authorization. I understand TTUHSC cannot be responsible for use or redisclosure of information by third parties.

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS: In consideration for receiving medical or health care services, I hereby assign my right, title, and interest in all insurance, Medicare/Medicaid, or other third-party payer benefits for medical or health care services otherwise payable to me to TTUHSC physicians and/or Medical Practice Income Plan. I also authorize direct payments to be made by Medicare/Medicaid and/or my insurance company or other third-party payer, up to the total amount of my medical and health care charges, to TTUHSC physicians and/or Medical Practice Income Plan. I certify that the information I have provided in connection with any application for payment by third-party payers, including Medicare/Medicaid, is correct.

I agree to pay all charges for medical and health care services not covered by or which exceed the amount estimated to be paid or actually paid by Medicare/Medicaid, my insurance company, or other third-party payer and agree to make payment as requested by TTUHSC.

I certify that this form has been fully explained to me, that I have read it or had it read to me*, and that I understand its contents.

ADVANCE DIRECTIVE: I have signed an Advance Directive. ____ YES ____ NO;
If yes, is it still in effect? ____YES ____ NO; I have provided a signed copy to TTUHSC. ____ YES ____ NO

NOTICE OF PRIVACY PRACTICES:

I have received a paper copy of TTUHSC's Notice of Privacy Practices. _____
(Patient's Initials)

_____/_____
DATE TIME

Patient/Other Legally Authorized Person

Witness/Translator*

Print Name and Relationship to Patient

Print Name and Translated Language