920 Medical Plaza Drive, Suite 450
Shenandoah, Texas 77380
Phone: 281.364.1700
Fax: 281.364.1710
Email:hightechfamily@yahoo.com
Website: www.htechfamily.com

CONSENT AND NOTICE OF PRIVACY PRACTICES

☐ I acknowledge receiving the **High Tech Family Care's** (referred to as "the clinic"), **Notice of Privacy Practices** (referred to as "Notice" or "NPP"). The Notice explains how the clinic may use and disclose your protected health information for treatment, payment and health care operations purpose. "Protected health information" means your personal health information found in your medical and billing records.

General Consent to Treat

☐ I am the patient or parent/guardian of (_____). I have the legal right to consent to medical and surgical treatment for patient. I voluntarily authorize and consent to such medical care, treatment, and diagnostic tests that the physicians, associates or assistants believe are necessary for this patient. I understand that by signing this form, I am giving permission to the doctors, nurses, physician assistants, and other health care providers at **High Tech Family Care** to provide treatment as long as I am a patient in this office or until I withdraw my consent.

Electronic Medical Records and Electronic Prescriptions

☐ I voluntarily authorize **High Tech Family Care** to allow E-Prescribing for the patient's mail order prescription, which allows the health care providers to electronically transmit prescriptions to the pharmacy of my choice; review pharmacy benefit information and medication dispense history as long as this child is a patient in this office, or until I withdraw my consent. I also allow release of ethnicity for purposes of electronic records tracking.

_____
Name of Patient

_____ _____
Name of Patient's Representative (Printed) Relationship to Patient

_____ _____
Signature of Patient or Patient's Representative Date