

**Women's Health Services
Consent for treatment**

By signing this consent, I am authorizing my physician(s) to perform and/or order another person to perform all exams, test, procedures, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Women's Health Services unless revoked by me orally or in writing.

Please be informed Texas law allows a patient to be tested for possible exposure to Human Immunodeficiency Virus (HIV), the virus associated with AIDS, in the following situations: 1) to screen blood, blood products, organs or tissues to determine suitability for donation; 2) if another individual is accidentally exposed to a patient's blood or bodily fluids, such as through a needle stick (any such test shall be conducted pursuant to Women's Health Services infection disease protocol); 3) if a medical or surgical procedure is to be performed which could expose health care workers to the patient's blood or bodily fluids. This disclosure is to inform you that you may be tested, at the expense of Women's Health Services, if any of these situations occur during your treatment period.

Date

Patient/Legal Representative

Authorization for release of information

I hereby authorize Women's Health Services to furnish information pertinent to my medical condition including but not limited to the diagnosis, treatment and care offered or rendered to me while a patient at Women's Health Services to the following entities: 1) to the insurer(s), including Medicare, to which my medical bills have been assigned for payment, 2) to consultants outside Women's Health Services who I may be referred to for care, and 3) to employees of Women's Health Services for conducting quality assurance and compliance activities. I understand that my records may be released to state and federal courts on issuance of a subpoena without my permission. I understand that my medical information will not be released to any persons other than who's named without my expressed written permission.

For the purpose of this release, "medical information" shall mean copies of all medical records, tests, x-ray, reports and/ or other materials in the possession of Women's Health Services relating to my medical condition and proposed or actual treatment. I understand that by signing this consent I am also authorizing release of any information contained with in the medical record which may be related to AIDS and/ or HIV antibody or antigen testing to the above mentioned persons.

By signing this consent for release of medical information. I agree not to hold Women's Health Services, their agents and employees liable for any unfavorable outcomes as the result of releasing this information. I realize that the release of my medical information may be necessary before my insurer will cover the cost of my medical treatment, and that by failing to authorize this release of this information, I may be required to pay the entire bill at the time of service

Date

Patient/Legal Representative

Patient's Name _____ Date of Birth _____
(please print)