Texas Children's Pediatrics

General Consent for Treatment

I have voluntarily presented for medical care and consent to such medical care and treatment including any diagnostic procedures and tests that the physician(s), his or her associates, assistants and other healthcare providers determine to be necessary. In the course of treatment, I understand and acknowledge that no warranty or guaranty has been or will be made as to the result or cure of treatment.

I consent to the taking of photographs or films related to the care and treatment and understand that such photographs or films may be made part of the medical record and/or used for internal purposes, such as performance improvement or education.

I have the legal right to consent to medical treatment because I am the patient or I am the parent/guardian of the patient. All references to "patient", "me" and "my" in this document means: _____ (name of patient).

Electronic Medical Record

We share medical records electronically with other health care providers to allow and promote continuity of care among providers. If you visit another provider who also participates in an electronic medical record system, they may have access to your medical record. If you do not want medical records shared with other providers please request and complete a Health Information Exchange Opt-out form.

Electronic Prescriptions (E-Prescribing)

I voluntarily authorize E-Prescribing for prescriptions, which allows health care providers to electronically transmit prescriptions to the pharmacy of my choice, review pharmacy benefit information and medication dispensing history as long as a physician/patient relationship exists.

Testing in Event of Healthcare Worker Exposure

I understand that in the event that a healthcare worker is accidentally exposed to the patient's blood or bodily fluids, or AIDS, pursuant to Texas law, I will be required to have blood tested to determine the presence of Hepatitis B or C surface antigen and/or Human Immunodeficiency Syndrome (HIV) antibodies. I understand that these tests are performed by withdrawing a small amount of blood and using substances to test the blood.

I acknowledge that these tests may, in some instances, indicate that a person has been exposed to these viruses when the person has not (false positive) or may fail to detect that a person has been exposed to these viruses when the person actually has been exposed (false negative). I understand that if any test is positive, I will receive counseling about the meaning of these tests as it relates to the herein-named patient's healthcare.

I understand that these test results will be kept confidential to the extent allowed by law and that unauthorized distribution of these test results is a criminal offense under state law.

Acknowledgments

I acknowledge that administrative data, demographic information and other health information describing patient care, services and outcomes are collected and used for healthcare operations, governmental and non-governmental reporting, and comparisons with other providers. In some instances, performance data is aggregated and reported per physician. In every instance, we make every reasonable effort to maintain patient and physician anonymity.

I acknowledge that I have received a Notice of Privacy Practices ("Notice"). The Notice explains how we may use and disclose the patient's protected health information for treatment, payment and health care operations purpose. "Protected health information" means the patient's personal health information found in the patient's medical and billing records. If you have questions about the Notice, please contact the Privacy Office at (832) 824-2091.

Advance Directive

The patient has an Advance Directive: Yes No

If yes, check all that apply: Directive to Physicians:☐ Medical Power of Attorney: ☐ Out of Hospital DNR: ☐

Please communicate the existence of any advance directive to your health care provider and provide copies for the medical record.

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

Patient's Name: _____

Patient's Date of birth (MM/DD/YYYY): _____

Name of Patient's Representative, if patient under 18 (Printed):

_____

Relationship of Patient's Representative if patient under 18:

_____

Signature of Patient or Patient's Representative: _____

Date: _____

Signature of Witness/Translator: _____

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