Tehmina Sami M.D P.A.
13440 University Blvd, Ste 180
Sugar Land, TX 77479

Phone: 281-994-7911
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Release of Health Information

Tehmina Sami M.D P.A. and its staff adhere to a policy of not releasing protected health information to individuals other than the patient. If you choose, you can designate others to receive your health information (check or put N/A below).

____________________ I authorize Tehmina Sami M.D P.A. to release protected healthcare information about myself to the following individual:

Name: ____________________________ Relationship: ____________________

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental services, and treatment for alcohol and drug abuse.

I understand that I can revoke or terminate this authorization by submitting a written revocation to the address listed below except to the extent that disclosure made in good faith has already occurred in reliance on this consent. If neither federal nor Texas privacy law apply to the recipient of the information, I understand that the information disclosed pursuant to this authorization may be re-disclosed by the recipient and no longer protected by federal or Texas privacy law.

I, ________________________, authorize Tehmina Sami M.D P.A. to register and release my immunization records to authorized persons/entities
(Self/Parent/Guardian)

____ ____________________________________
Signature of Patient, Parent or Legal Guardian Date

RECEIPT OF OFFICE POLICIES & PROCEDURES AND PRIVACY NOTICE

I have received/reviewed a copy of the Tehmina Sami M.D P.A. "Office Policies and Procedures for Our Patients" and "Notice of Privacy Practices" and the Patient Bill of Rights.

____ ____________________________________
Signature of Patient, Parent or Legal Guardian Date

CONSENT TO TREAT

I, the undersigned voluntarily give consent to my Tehmina Sami M.D P.A. medical professional to provide and perform such medical/ diagnostic/minor surgical treatment (s) and/or services as deemed advisable and necessary for the Diagnosis and/or treatment of my condition(s) or to maintain my health. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatment or examination in the office.

____________________________________ ____________________________________
Signature of Patient Date

Complete this <u>ONLY</u> if patient is a minor

I am the parent/guardian of ________________________________. I have the legal right and responsibility to obtain and consent to medical and surgical treatment for this patient. I voluntarily authorize and consent to such medical care and treatment that Tehmina Sami M.D P.A. medical professional believes is necessary for this child. I understand that by signing this form, and by bringing this child to this medical office for care, I am giving permission to the doctors and other heal care providers in this office to provide treatment to this patient as long as he/she is a patient of this medical practice.

____ ____________________________________
Signature of Patient, Parent or Legal Guardian Relationship