PREMIER
SPECIALTY PHYSICIANS
G.I. AND LIVER

Shahid Aziz, D.O. Omar Haq, M.D.
1650 W. Rosedale St. Suite 302 Fort Worth, Tx 76104
Phone: 817-885-7888 Fax: 817-885-7811

Patient Name: _____ DOB: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home#: _____ Cell#: _____ Alt#: _____

SS#: _____ Male: ____ Female: ____

Marital Status: (Circle one) Married Single Divorced Widow Partner Legally Separated

Email Address: _____

Primary Care Physician: _____

Pharmacy Name: _____ Phone#: _____

Employer Name: _____ Work#: _____

Emergency Contact: _____ Phone#: _____

Relationship to the patient: _____

Power of Attorney: _____ Phone#: _____

Insurance #1:

_____

Insured DOB: _____

Insurance #2:

_____

Insured DOB: _____

I, the undersigned, hereby authorize payment directly to Premier Specialty Physicians for medical services rendered. I understand I am financially responsible for all charges not covered or authorized by my insurance company.

I consent to treatment necessary to the care, which has been discussed and directed by the provider.

Printed Name: _____

Signature: _____ Date: _____

Please check all that apply:

Race

__American Indian __Asian __Black or African American __White __Other

Ethnicity

__Hispanic or Latino __Not Hispanic or Latino

Language

__English __Spanish __Hearing Impaired __Other

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Acknowledgment of Privacy Practices

According to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), patients have certain rights to privacy regarding their protected health information. By signing below you, the patient, acknowledge the following regarding the management of your protected health information. Your protected health information will be used to:

- Conduct, plan and direct treatment by the physicians employed by Premier Specialty Physicians and will be shared in cooperation with healthcare providers who are involved in your care directly or indirectly.
- To obtain payment from third party payers
- To conduct normal healthcare operations such as quality assessments and physician certifications.

By signing below you agree that you have either received or waived your right to receive the Notice of Privacy Practices, containing a complete description of the uses and disclosures of protected health information. You understand that this organization has the right to change its Notice of Privacy Practices at any time. You also understand that you may request from this organization a current copy of the Notice of Privacy Practices.

I understand that I may revoke this consent in writing at any time, except to the extent that Premier Specialty Physicians has previously released relying on this consent.

Do we have permission to?

- **leave a detailed message** regarding any appointments, treatments or test results at any of the following numbers we have on file for you: **Home**: __Yes __No **Cell**: __Yes __No **Work**: __Yes __No
- **mail detailed information** regarding appointments, treatments or test results to your home address: **__Yes __No**
- **email detailed information** regarding appointments, treatments or test results to the email address you have provided us with:
  __ Yes __No __N/A **Please ask for Patient Portal login if not already enrolled.**

Please list anyone you give us permission to discuss your medical records with:

NAME	RELATIONSHIP	CONTACT NUMBER

Patient's Signature: _____ Date: _____

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Authorization to Release Health Care Information

Please read this entire form before signing and complete all the sections that apply to your decisions relating to the disclosure of protected health information. Covered entities as that term is defined by HIPAA and Texas Health & Safety Code § 181.001 must obtain a signed authorization from the individual or the individual's legally authorized representative to electronically disclose that individual's protected health information. Authorization is not required for disclosures related to treatment, payment, health care operations, performing certain insurance functions, or as may be otherwise authorized by law. **Covered entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.** Individuals cannot be denied treatment based on a failure to sign this authorization form, and a refusal to sign this form will not affect the payment, enrollment, or eligibility for benefits.

Patient Name: _____ DOB: _____ SSN: _____

I request and authorize _____

Phone: _____ Fax: _____

To release the medical records of the patient named above to:

Shahid Aziz, DO Premier Specialty Physicians
1650 Rosedale Ste. 302 Fort Worth, TX 76104 817-885-7888 fax: 817-885-7811

WHAT INFORMATION CAN BE DISCLOSED? Complete the following by indicating those items that you want disclosed. The signature of a minor patient is required for the release of some of these items. If all health information is to be released, then check only the first box.

____ **All health information** ____History/Physical Exam ____Past/Present Medications ____Lab Results ____Physician's Orders
____Patient Allergies____ Operation Reports ____Consultation Reports ____Progress Notes ____Discharge Summary
____Diagnostic Test Reports ____Billing Information ____Other_____

Your initials are required to release the following information:

_____Mental Health Records (excluding psychotherapy notes)
_____Drug, Alcohol, or Substance Abuse Records
_____Genetic Information (including Genetic Test Results)
_____ HIV/AIDS Test Results/Treatment

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS Virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use, you are specifically authorized to release all health care information relating to such diagnosis, testing or treatment.

EFFECTIVE TIME PERIOD. This authorization is valid until the earlier of the occurrence of the death of the individual; the individual reaching the age of majority; or permission is withdrawn; or the following specific date (optional): Month _____ Day___ Year _____
RIGHT TO REVOKE: I understand that I can withdraw my permission at any time by giving written notice stating my intent to revoke this authorization to the person or organization named under "WHO CAN RECEIVE AND USE THE HEALTH INFORMATION." I understand that prior actions taken in reliance on this authorization by entities that had permission to access my health information will not be affected.
SIGNATURE AUTHORIZATION: I have read this form and agree to the uses and disclosures of the information as described. I understand that refusing to sign this form does not stop disclosure of health information that has occurred prior to revocation or that is otherwise permitted by law without my specific authorization or permission, including disclosures to covered entities as provided by Texas Health & Safety Code § 181.154(c) and/or 45 C.F.R. § 164.502(a)(1). I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal or state privacy laws

_____ _____
Signature of Patient or Patient's Authorized Representative Date Signed
Relationship or status if signed by anyone other than patient (parent, legal guardian, personal representative, etc.)