Hand & Upper Extremity Center of Dallas – Dr. Kimberly Mezera

Patient Information **Please Print**

O Dr. O Miss O Ms. O Mrs. O Mr. O Sr. O Jr. O Female O Male Date of Birth _____

Last Name _____ First Name _____ MI _____ SSN _____

Address _____ City, State _____ Zip _____

Cell Phone _____ Home Phone _____ Email _____

O White O Black O Asian O Native American O Pacific Islander O Declined O Hispanic O Not Hispanic O Declined

O English O Spanish O Other _____ O Single O Married O Divorced O Widowed O Separated O Partner

Employment: O Full-Time O Part-Time O Not Employed O Self Employed O Retired O Active Military Student: O Full-Time O Part-Time

Employer Name _____ Work Phone _____

Emergency Contact Name _____Relationship _____

Cell Phone _____ Home Phone _____ Alt Phone Number _____

Primary Care Physician _____ Referring Physician _____

Pharmacy _____ Phone Number _____ Living Will O Yes O No

Responsible Party **Information used for patient balance statements**

O Self O Spouse O Parent O Other _____ Date of Birth _____ SSN _____

Name _____ Phone Number _____

Address _____

Primary Insurance **Please provide copy of insurance card**

Insurance Company _____ Name of Insured _____

Relationship to Insured _____ Date of Birth _____ SSN _____

Policy Number _____ Group Number _____ Effective Date _____

Secondary Insurance **Please provide copy of insurance card**

Insurance Company _____ Name of Insured _____

Relationship to Insured _____ Date of Birth _____ SSN _____

Policy Number _____ Group Number _____ Effective Date _____

Assignment of Benefits and Financial Agreement

I hereby give lifetime authorization for payment of insurance benefits to be made to ***Hand & Upper Extremity Center of Dallas*** and any assisting physicians for the services rendered. I understand I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collections and reasonable attorney fees. I hereby authorize this healthcare provider to release all information necessary to secure payments of benefits. I further agree a photocopy of this agreement shall be as valid as the original.

Date _____ Patient Signature/Responsible Party _____

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Patient History Form **Please Complete/Update For Our Records**

This is a confidential record and information contained here will not be released without your consent

Today's Date _____ Date of Injury/Start of Problem _____ Date of Birth _____

Last Name _____ First Name _____ MI _____

Primary Care Physician _____ Referring Physician _____

Current Height _____ Current Weight _____ Chief Complaint _____

History of Present Illness

Please describe the problem in detail:

What, Where, When, How: _____

_____

What treatment have you received? _____

Have you had an X-Ray? O Yes O No MRI? O Yes O No CT? O Yes O No

Which hand is your dominant? O Right O Left Was this an injury? O Yes O No Did the injury occur at work? O Yes O No O N/A

Medical History

Have you ever had any of the following: Mark all that apply

O Hypertension O Diabetes O High Cholesterol O Blood Clots O Heart Disease O Hepatitis

O Heart Attack O Chest Pain O Stroke O Seizures O Ulcer O Cancer

O Blood transfusion O Anemia or Bleeding Problems O Other _____

If you answered yes to any of the above, when? _____

Surgeries/Hospitalizations

Have you ever had surgery? O Yes O No If so, What and When? _____

_____

Have you ever been hospitalized? O Yes O No If so, Why and When? _____

_____

Medications, Vitamins and Supplements

Please list the name, dosage and frequency of the Medication, Vitamin and/or Supplement

_____

_____

_____

Please list any ALLERGIES to medications, foods or environmental elements including the reaction experienced

_____

Family History

Does anyone in your family have any of the following; PLEASE LIST THE FAMILY MEMBER (i.e. mother, father, sister, brother, etc.)

O Heart Disease O Diabetes O Hypertension O Cancer O Arthritis O Other, List Below

_____

Social History

Do you smoke? O Yes O No If so, How much? _____ How long have you smoked? _____

Do you drink alcohol? O Yes O No If so, How much? _____

What is your occupation? _____ Are you currently working? O Yes O No If so, O Full-Duty O Light-Duty

What are your restrictions? _____

Review of Systems

Do you have a recent history of the following: Mark all that apply and please include details and dates of onset

O Weight Loss _____ O Eye Problems _____ O Ear, Nose, Throat Problems _____

O Psychiatric Treatment _____

O Heart Attack, Chest Pain, Irregular Heartbeat _____

O Ulcer or Digestive System Disorder _____

O Arthritis _____ O Skin Disorder _____ O Neurological Disorder _____

O Urinary, Bladder, Kidney Problems _____

O Other _____

Completed by _____ Date _____

I have read and reviewed this form with the patient:

Physician Signature _____ **Date** _____ **Time** _____

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Financial and Office Policies **By executing this agreement, you are agreeing to pay for all services received**

Filing Claims: Please be sure you inform us of any updates or changes to your insurance, so we have your current information. If we do not have current information this will delay payment and possibly cause you to have unexpected expenses. You will be asked to completely fill out a new information profile every year. These profiles expire one year after being signed.

Insured Patients: If we are contracted with your insurance company, we must follow our contract and its requirements. Your insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will bill your insurance company as a courtesy to you. Although we may estimate what your insurance company may pay, it is the insurance company who makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If you have a co-payment, co-insurance and/or deductible, you must pay at the time of service unless prior payment arrangements have been made. You agree to forward to **Hand & Upper Extremity Center of Dallas** all insurance or third party payments you receive for services rendered to you immediately upon receipt.

Self-Pay Patients: All self-pay patients are required to pay at the time the services are rendered unless prior payment arrangements have been made.

Insurance Verification: Our verification staff is dedicated to ensuring your visit is covered by your insurance or advising you otherwise prior to your appointment. In some instances, we might not be able to obtain this information. It is always a good idea for you to check with your insurance carrier to verify your specific benefits so there are no financial surprises at the time of your visit. Payment for services is ultimately your responsibility.

Statements: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued. It will separately show the previous balance, any new charges to the account, and any payments or credits applied to your account during the month.

Returned Checks: There is a fee (currently $25.00) for any checks returned by the bank.

Past Due Account: Your account becomes past due 30 days following receipt of your first statement, we will take necessary steps to collect this debt. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Waiver of Confidentiality: Please understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if you're past due status is reported to a credit reporting agency, the fact you received treatment at our office may become a matter of public record.

Appointments: It is our goal to provide services to you in the most comfortable and timely manner as possible. In order to achieve this we must require you to be on time for your appointments. If you must cancel an appointment, we ask you give us 24 hours notice whenever possible. Patients who are 15 or more minutes late may not be seen at the scheduled appointment time however may be worked back into the schedule as available. Missed appointments without notification may be charged a $25 fee which will need to be paid prior to next appointment. If you miss three appointments without notifying us before the appointment time you may be dismissed from the practice. In order to ensure accurate records and true identity of all patients you will need to present your Driver's License or Identification Card, Insurance Card and Social Security Number at the time of your appointment. If you are unable to provide this information your appointment may be cancelled or rescheduled.

Prescription Refills: If you need a prescription refilled, you will need to contact your pharmacy and request a refill authorization be faxed to the office to be processed by the clinical staff and approved by the physician.

Laboratory Test: Unless you instruct us otherwise, your labs will be sent to LabCorp. If your insurance requires you use Quest, Lab One or another lab not listed, please be sure to inform the nurse at the beginning of your appointment. Remember since we do send all lab specimens to an outside lab we do not charge for the actual test; the lab will bill you separately if your insurance does not cover them.

Result Notification: We will make every effort to notify you of results whether they are normal or abnormal. A phone call will be made to all patients regarding abnormal results. You may receive either a phone call or a healthy note informing you of normal results. Please allow one week for result notification. If you have not received notification of your results after one week, please call the office.

Telephone Calls: During office hours while the physician is attending other patients it is necessary for the staff to take detailed messages and pass along to the physician. If you are experiencing an emergency you will be advised to call 911 for assistance. If your call is of urgent nature a nurse will triage your call and consult the physician. Calls deemed non emergent will be handled by the office staff in the order they were received. If a call requires the physician to call you back it may be during hours after patient appointments.

Transferring of Records: All requests for medical records must be in writing and must adhere to all HIPAA requirements. All patients will receive one free copy of your medical records. If you require additional copies we will assess a fee according to the state statutes of $25.00 for the first 20 pages and $0.50 for every subsequent page.

Patient/Patient Representative Signature _____ **Date** _____

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General Consent to Treat

I, the undersigned, hereby consent to the following: Administration and performance of general treatments, use of prescribed medications, performance of diagnostic procedures/test and cultures, performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees. I fully understand this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended.

A photocopy of this consent shall be considered as valid as the original. I understand this form may include consent at other satellite offices under common ownership. I understand that while my consent is voluntary, if I refuse to sign this consent, the healthcare providers of **Hand & Upper Extremity Center of Dallas** may refuse to treat me. I understand these services are voluntary and I have the right to refuse these services.

I certify I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Patients Name _____ **Date of Birth** _____

Patient/Responsible Party Signature _____ **Date** _____

Hand & Upper Extremity Center of Dallas
Patient HIPAA Acknowledgment and Consent Form

Patient Name: _____

Date of Birth: _____

_____ **(Patient initials) Notice of Privacy Practices.** I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices.

_____ **(Patient initials) Release of Information.** I hereby permit practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior admission(s) at other HCA affiliated facilities may be made available to subsequent HCA-affiliated admitting facilities to coordinate Patient care or for case management purposes. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Disclosures to Friends and/or Family Members

I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1:			
2:			
3:			

Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications:

Patients in our practice may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our healthcare team, and to provide general health reminders/information.

If at any time I provide an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ **(Patient initials)** I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text messages for appointment reminders, feedback, and general health reminders/information is_____.

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is_____.

The practice does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Revocation

I hereby revoke my request for future communications via email and/or text.

__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.

__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

NOTE: This revocation only applies to communications from this Practice.

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____ Time: _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations

____ **(Patient Initials)** I consent to photographs, videotapes, digital or audio recordings, and/or images of me being recorded for security purposes and/or the practice's health care operations purposes (e.g., quality improvement activities). I understand that the facility retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used without a specific written authorization from me or my legal representative unless it is for treatment, payment or health care operations purposes or otherwise permitted or required by law.

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

____ **(Patient initials)** I wish to designate the following family member / friend to pick up an order on my behalf:

Name: _____ Date: _____

Name: _____ Date: _____

____ **(Patient initials)** I do not want to designate anyone to pick-up my prescription order.

Patient Signature _____ **Date:** _____

Hand & Upper Extremity Center of Dallas
NOTICE OF PRIVACY PRACTICES
Effective Date: 09.23.2013

PLEASE REVIEW IT CAREFULLY. PATIENT'S COPY

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

If you have any questions about this notice, please contact the Facility Privacy Official by dialing the main facility number.

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, a plan for future care or treatment, and billing-related information. This notice applies to all of the records of your care generated by the facility, whether made by facility personnel, agents of the facility, or your personal doctor. Your personal doctor may have different policies or notices regarding the doctor's use and disclosure of your health information created in the doctor's office or clinic.

Our Responsibilities: We are required by law to maintain the privacy of your health information, provide you a description of our privacy practices, and to notify you following a breach of unsecured protected health information. We will abide by the terms of this notice

Uses and Disclosures

How we may use and disclose Health Information about you.

The following categories describe examples of the way we use and disclose health information:

For Treatment: We may use health information about you to provide you treatment or services. We may disclose health information about you to doctors, nurses, technicians, medical students, or other facility personnel who are involved in taking care of you at the facility. For example: a doctor treating you for a broken leg may need to know if you have diabetes because diabetes may slow the healing process. Different departments of the facility also may share health information about you in order to coordinate the different things you may need, such as prescriptions, lab work, meals, and x-rays.

We may also provide your physician or a subsequent healthcare provider with copies of various reports that should assist him or her in treating you once you're discharged from this facility.

For Payment: We may use and disclose health information about your treatment and services to bill and collect payment from you, your insurance company or a third party payer. For example, we may need to give your insurance company information about your surgery so they will pay us or reimburse you for the treatment. We may also tell your health plan about treatment you are going to receive to determine whether your plan will cover it.

For Health Care Operations: Members of the medical staff and/or quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. The results will then be used to continually improve the quality of care for all patients we serve. For example, we may combine health information about many patients to evaluate the need for new services or treatment. We may disclose information to doctors, nurses, and other students for educational purposes. And we may combine health information we have with that of other facilities to see where we can make improvements. We may remove information that identifies you from this set of health information to protect your privacy.

Fundraising: We may contact you to raise funds for the facility; however, you have the right to elect not to receive such communications.

We may also use and disclose health information:

- To remind you that you have an appointment for medical care;
- To assess your satisfaction with our services;
- To tell you about possible treatment alternatives;
- To tell you about health–related benefits or services;
- For population based activities relating to improving health or reducing health care costs;
- For conducting training programs or reviewing competence of health care professionals; and
- To a Medicaid eligibility database and the Children's Health Insurance Program eligibility database, as applicable.

When disclosing information, primarily appointment reminders and billing/collections efforts, we may leave messages on your answering machine/voice mail.

Business Associates: There are some services provided in our organization through contracts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, business associates are required by federal law to appropriately safeguard your information.

Directory: We may include certain limited information about you in the facility directory while you are a patient at the facility. The information may include your name, location in the facility, your general condition (*e.g.*, good, fair) and your religious affiliation. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name. If you would like to opt out of being in the facility directory please request the Opt Out Form from the admission staff or Facility Privacy Official.

Individuals Involved in Your Care or Payment for Your Care and/or Notification Purposes: We may release health information about you to a friend or family member who is involved in your medical care or who helps pay for your care or to notify, or assist in the notification of (including identifying or locating), a family member, your personal representative, or another person responsible for your care of your location and general condition. In addition, we may disclose health information about you to an entity assisting in a disaster relief effort in order to assist with the provision of this notice.

Research: The use of health information is important to develop new knowledge and improve medical care. We may use or disclose health information for research studies but only when they meet all federal and state requirements to protect your privacy (such as using only de-identified data whenever possible). You may also be contacted to participate in a research study.

Future Communications: We may communicate to you via newsletters, mail outs or other means regarding treatment options, health related information, disease-management programs, wellness programs, research projects, or other community based initiatives or activities our facility is participating in.

Organized Health Care Arrangement: This facility and its medical staff members have organized and are presenting you this document as a joint notice. Information will be shared as necessary to carry out treatment, payment and health care operations. Physicians and caregivers may have access to protected health information in their offices to assist in reviewing past treatment as it may affect treatment at the time.

Affiliated Covered Entity: Protected health information will be made available to facility personnel at local affiliated facilities as necessary to carry out treatment, payment and health care operations. Caregivers at other facilities may have access to protected health information at their locations to assist in reviewing past treatment information as it may affect treatment at this time. Please contact the Facility Privacy Official for further information on the specific sites included in this affiliated covered entity.

Health Information Exchange/Regional Health Information Organization: Federal and state laws may permit us to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share your health information with one another to

accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of your health records; decreasing the time needed to access your information; aggregating and comparing your information for quality improvement purposes; and such other purposes as may be permitted by law.

As required by law. We may disclose information when required to do so by law.

As permitted by law, we may also use and disclose health information for the following types of entities, including but not limited to:

- Food and Drug Administration
- Public Health or Legal Authorities charged with preventing or controlling disease, injury or disability
- Correctional Institutions
- Workers Compensation Agents
- Organ and Tissue Donation Organizations
- Military Command Authorities
- Health Oversight Agencies
- Funeral Directors and Coroners
- National Security and Intelligence Agencies
- Protective Services for the President and Others
- A person or persons able to prevent or lessen a serious threat to health or safety

Law Enforcement: We may disclose health information to a law enforcement official for purposes such as providing limited information to locate a missing person or report a crime.

For Judicial or Administrative Proceedings: We may disclose protected health information as permitted by law in connection with judicial or administrative proceedings, such as in response to a court order, search warrant or subpoena.

Authorization Required: We must obtain your written authorization in order to use or disclose psychotherapy notes, use or disclose your protected health information for marketing purposes, or to sell your protected health information.

State-Specific Requirements: Many states have requirements for reporting including population-based activities relating to improving health or reducing health care costs. Some states have separate privacy laws that may apply additional legal requirements. If the state privacy laws are more stringent than federal privacy laws, the state law preempts the federal law.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, you have the **Right to**:

- **Inspect and Copy:** You have the right to inspect and obtain a copy of the health information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to health information, you may request that the denial be reviewed. Another licensed health care professional chosen by the facility will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.
- **Amend:** If you feel that health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for the facility. Any request for an amendment must be sent in writing to the Facility Privacy Official.
  We may deny your request for an amendment and if this occurs, you will be notified of the reason for the denial.
- **An Accounting of Disclosures:** You have the right to request an accounting of disclosures. This is a list of certain disclosures we make of your health information for purposes other than treatment, payment or health care operations where an authorization was not required.
- **Request Restrictions:** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. Any request for a restriction must be sent in writing to the Facility Privacy Official.
- We are required to agree to your request ***only*** if 1) except as otherwise required by law, the disclosure is to your health plan and the purpose is related to payment or health care operations (and not treatment purposes), **and** 2) your information pertains solely to health care services for which you have paid in full. **For other requests, we are not required to agree.** If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
- **Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we contact you at work instead of your home. The facility will grant reasonable requests for confidential communications at alternative locations and/or via alternative means only if the request is submitted in writing and the written request includes a mailing address where the individual will receive bills for services rendered by the facility and related correspondence regarding payment for services. Please realize, we reserve the right to contact you by other means and at other locations if you fail to respond to any communication from us that requires a response. We will notify you in accordance with your original request prior to attempting to contact you by other means or at another location.
- **A Paper Copy of This Notice:** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.
  If the facility has a website you may print or view a copy of the notice by clicking on the Notice of Privacy Practices link.

To exercise any of your rights, please obtain the required forms from the Privacy Official and submit your request in writing.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and the revised or changed notice will be effective for information we already have about you as well as any information we receive in the future. The current notice will be posted in the facility and on our website and include the effective date. In addition, each time you register at or are admitted to the facility for treatment or health care services as an inpatient or outpatient, we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the facility by following the process outlined in the facility's Patient Rights documentation. You may also file a complaint with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing.

You will not be penalized for filing a complaint

OTHER USES OF HEALTH INFORMATION

Other uses and disclosures of health information not covered by this notice or the laws that apply to us will be made only with your written authorization. If you provide us permission to use or disclose health information about you, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your authorization, and that we are required to retain our records of the care that we provided to you.

FACILITY PRIVACY OFFICIAL

Gloria Elena Alvarez **972-566- 5051**