SOUTH ALAMO MEDICAL GROUP

Patient Information

Last Name	First Name	Middle Name	M F Gender	Date of Birth

Social Security Number	Home Phone #	Cellular Phone #

Work Phone #	Ext	Race	Ethnicity	S M W Martial Status

Home Address	Apt #	City	State	Zip Code

Driver License # or ID #	Email

Responsible Party (Parent/Guardian) - Guarantor Information

Last Name	First Name	Middle Name	M F Gender	Date of Birth

Social Security Number	Home Phone #	Cellular Phone #

Home Address	Apt #	City	State	Zip Code

Driver License # or ID #	Work Phone #	Ext	Email

Primary Insurance Information

Insurance Company Name	Policy Holder	ID#	Group #

Social Security Number	Date of Birth	Relationship	Employer

Claim's Address	City	State	Zip Code

Secondary Insurance Information

Insurance Company Name	Policy Holder	ID#	Group #

Social Security Number	Date of Birth	Relationship	Employer

Claim's Address	City	State	Zip Code

Assignment of Benefits

I hereby assign to SAMG any insurance or other third-party benefits available for health care services provided to me. I understand that SAMG has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to SAMG, I agree to forward to SAMG all the ins and +other third-party payments that I receive for services rendered to me immediately upon receipt.

Signature of Insured _____ Date _____

Release of Information

I hereby authorize Physician to release any information acquired in the course of my examination or treatment. (Insurance company or other healthcare providers.)

Signature of insured _____ Date _____

Guardian Information

If unable to bring minor to clinic, please list below names of individuals who are authorized to bring minor for office visit.

Print Name _____ Relationship _____

Print Name _____ Relationship _____

Referral Source

How did you hear about us?

- ☐ Insurance Company
- ☐ Health Fair
- ☐ Patient's Liaison: Elizabeth Trevino
- ☐ Someone referred you: _____
- ☐ Drove by
- ☐ Other _____

SOUTH ALAMO MEDICAL GROUP

"Our mission is to provide exceptional health care services with compassion and promptness."

NOTICE OF PRIVACY PRACTICES

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

PLEASE REVIEW CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This notice takes effect **April 14, 2003** and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change the Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For Example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operation. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

You're Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help you with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information 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, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosure. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, X-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required By Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request a copy by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you According to our Medical Record fees (see on last page) to locate and copy your health information, and postage of you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure).

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclose your health information for purposes, other that treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree with these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location your request.

Electronic Notice: If you receive this Notice on your Web site or by electronic mail (e-mail), you are entitled to receive this notice in written form.

Questions, Compliments or Complaints

If you want more information about our privacy practices or have any questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations you may complain to us using the contact information listed at the end of this Notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: **Rebecca Beltran, Patient Liaison**
Telephone: (210) 928-4894 Fax: (210) 928-4806
Email: rbeltran@samedgrp.com

BOX 240490, San Antonio, TX 78224

SOUTH ALAMO MEDICAL GROUP

"Our mission is to provide exceptional health care services with compassion and promptness."

Acknowledgement of Notice of Privacy Practices

Patient's signature acknowledging receipt of the practice's "Notice of Privacy Practices."

Patient Name: _____

Patient's Date of Birth: _____

Signature: _____

Date: _____

All mail must be sent to South Alamo Medical Group, PO Box 240490, San Antonio, TX 78224

Centralized Office Phone # 210-222-0333
Centralized Fax # 210-928-4837

Downtown	**Pediatrics**	**Southside**	**Southeast**	**Northwest *NEW**
740 South Alamo	7355 Barlite, Ste 201	7355 Barlite, Ste 301	4203 E. Southcross	9215 Westover Hills Blvd
210-222-0333	210-222-0333	210-222-0333	210-222-0333	210-222-0333
Fax 210-928-4837	Fax 210-928-4837	Fax 210-928-4837	Fax 210-928-4837	Fax 210-928-4837

SOUTH ALAMO MEDICAL GROUP
PATIENT FINANCIAL POLICY

Thank you for choosing South Alamo Medical Group (SAMG) as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities***. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, phone contact and email etc).***

Co-pays

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted.

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. ***If your insurance plan is one with which we are not a participating provider, you will be responsible for payment in full. Including but not limited to those charges above the usual and customary allowance. However, as a courtesy, we will file your initial insurance claim and if not paid within 30 days you will be responsible.***

Self-pay Accounts

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with your information, the patient will be considered self-pay unless otherwise proven. Self-pay patients will be required to bring the cost of the office visit at the initial appointment and will be asked to make payment arrangements for the balance. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

Revised: 3/1/2016

SOUTH ALAMO MEDICAL GROUP
PATIENT FINANCIAL POLICY

Financial Assistance Program

South Alamo Medical Group will offer a Sliding Fee Discount Program to all who are unable to pay for their services and receive care at the following locations 7355 Barlite Suite's 301, 201 and 4203 E. Southcross Blvd. SAMG will base program eligibility on a person's ability to pay and will not discriminate on the basis of age, gender, race, creed, disability or national origin. The Federal Poverty Guidelines, https://aspe.hhs.gov/poverty-guidelines are used in creating and annually updating the sliding fee schedule (SFS) to determine eligibility. Please ask our admitting staff to see if you qualify for this program.

We do not do any Motor Vehicle Accident (MVA) and Third Party Billing and/or Workers' Compensation. SAMG will refer you to medical providers that will provide you this type of care.

Claims Department Contact information:

If you need assistance or have questions, please contact the Billing Department between 8:00 a.m. and 4:30 p.m., Monday through Friday at 210-242-2000

MEDICARE:

We accept assignment on Medicare claims. Medicare patients will be expected to pay their yearly deductible (if not met) and 20% co-payment. If at the time of service you provide Medicare card and have an HMO replacement with other Primary care provider, you will be fully responsible for the services provided to you.
*****Medicare Yearly Deductible of $166.00 for 2016*****

MEDICAID:

If your coverage is active, we will file your claim. Please bring proof of coverage to each visit. If at the time of service you provide Medicaid card and have an HMO replacement with other Primary care provider, you will be fully responsible for the services provided to you.

LABORATORY TESTING:

As a courtesy to our patients, lab drawing will be provided by a laboratory company ***(not associated with our group SAMG)*** participating with your insurance carrier, they will bill you. If you have any laboratory billing questions, please contact them directly.

MISSED APPOINTMENTS/LATE CANCELLATIONS:

Broken appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations are requested 24 hours prior to the appointment. ***We reserve the right to charge $15.00 for missed or late canceled appointments.*** Excessive abuse of scheduled appointments may result in discharge from the practice.

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

Revised: 3/1/2016

SOUTH ALAMO MEDICAL GROUP
PATIENT FINANCIAL POLICY

Returned Checks
The charge for a returned check is $35 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a cash only basis following any returned check.

Medical Record Copies
Patients, Attorneys and Insurance companies requesting copies of medical records will be charged:
$25 – 1 to 20 pages
$0.50 each additional page

A special handling fee of $10 will be charged if records must be delivered within 48 hours of the request.

Minors
The parent(s) or guardian(s) is responsible for full payment at the time of service. A signed release to treat is required for unaccompanied minors.

Outstanding Balance Policy
It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, or attorney, and possible discharge from the practice.

In the event an account is turned over for collections, the person financially responsible for the account will be responsible for all collections costs including attorney fees and court costs.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

I have read and understand the South Alamo Medical Group Patient Financial Policy. I agree to assign insurance benefits to the South Alamo Medical Group whenever necessary. I also agree not to approach the doctor with any money matters; I'm to discuss any such issues with the Claims Department Coordinator.

Signature of insured or authorized representative _____ Date _____

This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us.

Revised: 3/1/2016

SOUTH ALAMO MEDICAL GROUP

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Medical Release Authorization

I hereby authorize the following people to receive any and all test results, general medical condition and your diagnosis (including treatments and billing). I also understand that information relevant to HIV testing and/or AIDS related diagnosis may be contained in this information. This list also includes people who can be reached in an emergency situation.

Print Name	Relation	Phone Number	Email
Print Name	Relation	Phone Number	Email
Print Name	Relation	Phone Number	Email

Please print an address of where you would like your billing statements and/or correspondence from our office to be sent **if different than address already provided to us.**

Address	Apt#/PO BOX	City	State

Please indicate if you want all correspondence from our office sent in a sealed envelope.

☐Yes ☐No

Please indicate if a confidential message can be left on your telephone/cell phone answering machine or voicemail.

☐Yes ☐No

(*Please check one box below*)

☐ **I DO authorize anyone listed above to receive any test results or medical history.**

☐ **I DO NOT authorize anyone to receive any test results or medical history.**

Patient Print	Name Signature	Date

I will not hold South Alamo Medical Group Physicians or Staff responsible for release of information related to the above without my signature.

Under no Circumstances can any changes be made verbally.

All mail must be sent to South Alamo Medical Group, PO Box 240490, San Antonio, TX 78224

Centralized Office Phone # 210-222-0333

Centralized Fax # 210-928-4837

Downtown	**Pediatrics**	**Southside**	**Southeast**	**Northwest *NEW**
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Letter of Consent for Photographing Patients

I, _____, authorize South Alamo Medical Group

to photograph _____.

I understand that this photograph is to be kept in the patients file and to be used for medical record clarification purpose only.

All photographs are kept confidential as are all medical records according to the Health Insurance Portability and Accountability Act (HIPAA).

Print Patient Name: _____

DOB: _____

Signature: _____

Date: _____

All mail must be sent to South Alamo Medical Group, PO Box 240490, San Antonio, TX 78224
Centralized Office Phone # 210-222-0333
Centralized Fax # 210-928-4837

Downtown	**Pediatrics**	**Southside**	**Southeast**	**Northwest**
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Fax 210-928-4837	Fax 210-928-4837	Fax 210-928-4837	Fax 210-928-4837	Fax 210-928-4837

SOUTH ALAMO MEDICAL GROUP

By signing below, I consent South Alamo Medical Group permission to access my pharmacy benefits electronically through RX Hub. My consent will allow South Alamo Medical Group to:

- Determine the pharmacy benefits and drug co-pays
- Verify whether a prescribed medication is covered under the insurance plan formulary.
- Display medication alternatives that are on the insurance formulary.
- Download a list of all medications that have been prescribed
- Obtain my prescription benefits and information on other prescriptions prescribed to me by other providers outside of South Alamo Medical Group.

_____ _____

Patient Name Date of Birth

_____ _____

Parent Name Parent Signature

_____

Date

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

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.

NAME OF PATIENT OR INDIVIDUAL

_____
Last First Middle

OTHER NAME(S) USED _____

DATE OF BIRTH Month _____ Day _____ Year _____

ADDRESS _____

_____

CITY _____ **STATE** _____ **ZIP** _____

PHONE (_____)_____ **ALT. PHONE** (_____)_____

EMAIL ADDRESS (Optional): _____

I AUTHORIZE THE FOLLOWING TO DISCLOSE THE INDIVIDUAL'S PROTECTED HEALTH INFORMATION:

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (_____)_____ Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____
Phone (210)_____ Fax (_____)_____

REASON FOR DISCLOSURE
(Choose only one option below)

- ☐ Treatment/Continuing Medical Care
- ☐ Personal Use
- ☐ Billing or Claims
- ☐ Insurance
- ☐ Legal Purposes
- ☐ Disability Determination
- ☐ School
- ☐ Employment
- ☐ Other _____

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**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Billing Information
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Radiology Reports & Images
- ☐ Lab Results
- ☐ Consultation Reports
- ☐ EKG/Cardiology Reports
- ☐ 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

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 X_____ _____
Signature of Individual or Individual's Legally Authorized Representative **DATE**

Printed Name of Legally Authorized Representative (if applicable): _____
If representative, specify relationship to the individual: ☐ Parent of minor ☐ Guardian ☐ Other _____

A minor individual's signature is required for the release of certain types of information, including for example, the release of information related to certain types of reproductive care, sexually transmitted diseases, and drug, alcohol or substance abuse, and mental health treatment (See, e.g., Tex. Fam. Code § 32.003).

SIGNATURE X_____ _____
Signature of Minor Individual **DATE**

IMPORTANT INFORMATION ABOUT THE AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Developed for Texas Health & Safety Code § 181.154(d)
effective June 2013

The Attorney General of Texas has adopted a standard Authorization to Disclose Protected Health Information in accordance with Texas Health & Safety Code § 181.154(d). This form is intended for use in complying with the requirements of the Health Insurance Portability and Accountability Act and Privacy Standards (HIPAA) and the Texas Medical Privacy Act (Texas Health & Safety Code, Chapter 181). **Covered Entities may use this form or any other form that complies with HIPAA, the Texas Medical Privacy Act, and other applicable laws.**

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. (Tex. Health & Safety Code §§ 181.154(b),(c), § 241.153; 45 C.F.R. §§ 164.502(a)(1); 164.506, and 164.508).

The authorization provided by use of the form means that the organization, entity or person authorized can disclose, communicate, or send the named individual's protected health information to the organization, entity or person identified on the form, including through the use of any electronic means.

Definitions - In the form, the terms "treatment," "healthcare operations," "psychotherapy notes," and "protected health information" are as defined in HIPAA (45 CFR 164.501). "Legally authorized representative" as used in the form includes any person authorized to act on behalf of another individual. (Tex. Occ. Code § 151.002(6); Tex. Health & Safety Code §§ 166.164, 241.151; and Tex. Probate Code § 3(aa)).

Health Information to be Released - If "All Health Information" is selected for release, health information includes, but is not limited to, all records and other information regarding health history, treatment, hospitalization, tests, and outpatient care, and also educational records that may contain health information. As indicated on the form, specific authorization is required for the release of information about certain sensitive conditions, including:

- Mental health records (excluding "psychotherapy notes" as defined in HIPAA at 45 CFR 164.501).
- Drug, alcohol, or substance abuse records.
- Records or tests relating to HIV/AIDS.
- Genetic (inherited) diseases or tests (except as may be prohibited by 45 C.F.R. § 164.502).

Note on Release of Health Records - This form is not required for the permissible disclosure of an individual's protected health information to the individual or the individual's legally authorized representative. (45 C.F.R. §§ 164.502(a)(1)(i), 164.524; Tex. Health & Safety Code § 181.102). If requesting a copy of the individual's health records with this form, state and federal law allows such access, unless such access is determined by the physician or mental health provider to be harmful to the individual's physical, mental or emotional health. (Tex. Health & Safety Code §§ 181.102, 611.0045(b); Tex. Occ. Code § 159.006(a); 45 C.F.R. § 164.502(a)(1)). If a healthcare provider is specified in the "Who Can Receive and Use The Health Information" section of this form, then permission to receive protected health information also includes physicians, other health care providers (such as nurses and medical staff) who are involved in the individual's medical care at that entity's facility or that person's office, and health care providers who are covering or on call for the specified person or organization, and staff members or agents (such as business associates or qualified services organizations) who carry out activities and purposes permitted by law for that specified covered entity or person. If a covered entity other than a healthcare provider is specified, then permission to receive protected health information also includes that organization's staff or agents and subcontractors who carry out activities and purposes permitted by this form for that organization. Individuals may be entitled to restrict certain disclosures of protected health information related to services paid for in full by the individual (45 C.F.R. § 164.522(a)(1)(vi)).

Authorizations for Sale or Marketing Purposes - If this authorization is being made for sale or marketing purposes and the covered entity will receive direct or indirect remuneration from a third party in connection with the use or disclosure of the individual's information for marketing, the authorization must clearly indicate to the individual that such remuneration is involved. (Tex. Health & Safety Code §181.152, .153; 45 C.F.R. § 164.508(a)(3), (4)).

Limitations of this form - This authorization form shall not be used for the disclosure of any health information as it relates to: (1) health benefits plan enrollment and/or related enrollment determinations (45 C.F.R. § 164.508(b)(4)(ii), .508(c)(2)(ii); (2) psychotherapy notes (45 C.F.R. § 164.508(b)(3)(ii); or for research purposes (45 C.F.R. § 164.508(b)(3)(i)). **Use of this form does not exempt any entity from compliance with applicable federal or state laws or regulations regarding access, use or disclosure of health information or other sensitive personal information (e.g., 42 CFR Part 2, restricting use of information pertaining to drug/alcohol abuse and treatment), and does not entitle an entity or its employees, agents or assigns to any limitation of liability for acts or omissions in connection with the access, use, or disclosure of health information obtained through use of the form.**

Charges - Some covered entities may charge a retrieval/processing fee and for copies of medical records. (Tex. Health & Safety Code § 241.154).

Right to Receive Copy - The individual and/or the individual's legally authorized representative has a right to receive a copy of this authorization.

South Alamo Medical Group provides this site in partnership with e-MDs® with the exclusive use of its established patients. The patient portal is designed to enhance – physician communications. We strive to keep all of the information in your records correct and complete. If you identify any discrepancy on your record, you agree to notify us immediately. The patient portal website is https://www.healthportalsite.com/samedgrp. South Alamo Medical Group's main website is http://www.samedgrp.com.

South Alamo Medical Group Authorization for Patient Portal Access

Please complete the following section.

Patient Name: _____
Last First Middle Name (if applicable)

Address: _____

City: _____ State: _____ Zip: _____ DOB: _____

Patient e-Mail Address (if available): _____

The Patient Portal will give you the ability to do the following:

- Request an appointment or medication refill
- Obtain lab results or request a referral
- Message your clinician or a billing question
- View child's health summary

Granting Proxy Access

Complete this section **ONLY** if you would like to give someone else access to your medical record information

Proxy access gives someone that you trust (e.g., parent, spouse, etc.) the ability to view your medical record information on the internet using e-MDs Patient Portal and have access to the above medical information. Proxy access will also allow the designated person(s) the ability to update/modify your patient profile information, including email address and Portal password. You may cancel your Proxy's access at any time by completing the "Revocation of Proxy Access" section.

I hereby authorize *South Alamo Medical Group* to give the following appointed Proxy access to my online health record using e-MDs Patient Portal.

Proxy's Name: _____
Last First Middle Name (if applicable)

Address: _____

City: _____State: _____ Zip: _____ __ DOB: _____

Proxy's e-Mail: _____Relationship to Patient: _____

REMEMBER: Please sign under the "Authorization of Information" section to confirm your Proxy's access.

SOUTH ALAMO MEDICAL GROUP

Authorization for Release of Information

SIGN HERE to authorize you and/or your Proxy's access to the Patient Portal

As the patient, I hereby authorize South Alamo Medical Group (SAMG) to release my health information using the South Alamo Medical Group Authorization for Patient Portal Access form. I understand and acknowledge that access may include the patient's treatment for physical and mental health illness, alcohol / drug abuse, and / or HIV / AIDS (confidential) test results or diagnoses, if applicable. I understand that authorizing the disclosure of this health information is voluntary and I can refuse to sign this authorization. I understand that at any time I may discontinue my Patient Portal access as a patient or discontinue my proxy's access by filling the Revocation of Proxy Access section below.

By signing below, you agree that SAMG reserves the right to change, suspend or terminate your authorized access at our own discretion. I understand that revocation will not apply to information that has already been released in response / reliance on this authorization. I understand that SAMG does not condition any of my health treatment, payment or other services on whether I provide this authorization. I understand that this form does not authorize the release of patient records to the designated proxy by other methods or means. I understand that once information has been disclosed and / or downloaded, the information may potentially be re-disclosed and may not be covered by privacy protections. I understand if I download my health information to a computer or other electronic device, I am solely responsible to protect this information.

_____	_____	_____
Date	Patient Print Name	Patient Signature

Revocation of Proxy Access

Complete this section **ONLY** if you would like to cancel the current Proxy's access to your medical record information

I elect to revoke authorization of the South Alamo Medical Group's Patient Portal access to the Proxy listed on the first page of this form, except to the extent that South Alamo Medical Group has relied on my previous authorization. This revocation will not have any effect on any actions taken prior to receiving the revocation.

_____	_____	_____
Date	Patient Print Name	Patient Signature

SOUTH ALAMO MEDICAL GROUP

NURSE PRACTIONER-APN
Consent for Treatment

This facility has on staff an advance practice nurse to assist in the delivery of medical care.

An advance practice nurse is not a doctor. An advance practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advance practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advance practice nurse may treat minor lacerations and other minor injuries.

I have read the above, and hereby consent to the services of an advance practice nurse for my health care needs.

I understand that at any time I can refuse to see the advance practice nurse and request to see a physician.

Name:	Date
Signature:	Witness: (optional)

SOUTH ALAMO MEDICAL GROUP

PHYSICIAN ASSISTANT
Consent for Treatment

This facility has on staff a physician assistant to assist in the delivery of medical care.

A physician assistant is not a doctor. A physician assistant is a graduate of a certified training program and is licensed by the state board. Under the supervision of a physician, a physician assistant can diagnose, treat and monitor common acute and chronic diseases as well as provide health maintenance care.

"Supervision" does not require the constant physical presence of a supervising physician, but rather overseeing the activities of and accepting responsibility for the medical services provided.

A physician assistant may provide such medical services that are within his/her education, training and experience. These services may include:

- Obtaining histories and performing physical exams
- Ordering and/or performing diagnostic and therapeutic procedures
- Formulating a working diagnosis
- Developing and implementing a treatment plan
- Monitoring the effectiveness of therapeutic interventions
- Assisting at surgery
- Offering counseling and education
- Supplying sample medications and writing prescriptions (where allowed by law)
- Making appropriate referrals

I have read the above, and hereby consent to the services of a physician assistant for my health care needs.

I understand that at any time I can refuse to see the physician assistant and request to see a physician.

Name:	Date
Signature:	Witness: (optional)