Samuel E. Steinmetz, M.D.
8210 Walnut Hill Lane, Suite 414
Dallas, Texas 75231
(214)363-6226

Patient Consent Form

I understand that as a part of my healthcare, Dr. Samuel Steinmetz ("PHYSICIAN") originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, and to communicate with other healthcare providers.

The PHYSICIAN'S *Notice of Privacy Practices* provides specific information and complete description of how my personal health information may be used and disclosed. I have the right to review the notice prior to signing this consent. I understand that the PHYSICIAN reserves the right to change the *Notice of Privacy Practices*. If revised, the revised *Notice* will be provided to me if I contact the PHYSICIAN'S office. I understand that I have right to restrict the use and/or disclosure of my personal health information for treatment, payment or healthcare operations and that the PHYSICIAN is not required to agree to the restrictions requested. I may revoke this consent at any time in writing except to the extent that the PHYSICIAN has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing. The PHYSICIAN'S practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

I further understand that any and all records, whether written, oral, or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

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Signature of Patient or Legal Representative Date

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Print Name of Patient or Legal Representative