Texas Kidney INSTITUTE **Consent For Medical Care and Treatment (RX and Research)**

I, _____, understand that I may have a medical condition that could possibly require diagnosis and treatment. I do hereby voluntarily consent to such treatment, services, and procedures that may be recommended under the general and specific instructions of the physicians of Texas Kidney Institute, his/her assistants, or his/her designee.

I acknowledge that the practice of medicine is not an exact science and that the physicians of Texas Kidney Institute have made no guarantees to me as to the result of treatments or examination.

Texas Kidney Institute recognizes the importance and significance of maintaining confidentiality of information retarding a patient's medical condition. We also want to provide our patients timely communication as to laboratory/diagnostic test results, etc. We understand that because of the patient's schedules and our office schedule this may sometimes be difficult. Texas Kidney Institute would not, under any circumstance, leave messages regarding sensitive medical information.

Acknowledging that it may be difficult for the physician/physician's staff to personally communicate with the patients regarding laboratory/diagnostic test results, etc. it is the policy of Texas Kidney Institute to leave this information on patients' telephone answering machine.

If the physician/physician's staff cannot reach the patient at home or business telephone, it is the policy of Texas Kidney Institute that a message will be left with the person that answers the telephone to advise the patient to return the phone call.

It is the policy of Texas Kidney Institute not to release confidential medical information to patient's family members. We cannot discuss your medical condition, or release diagnostic test results to any one without your consent.

It is the policy of Texas Kidney Institute to participate in clinical research designed to improve quality of patient care; this may necessitate the review of the patient's medical records by the research staff.

_____ I agree **_____ I disagree**

I authorize Texas Kidney Institute to view my prescription history from external sources

_____ I agree **_____ I disagree**

Signature of Patient:_____ Date: _____

Texas Kidney Institute
www.texaskidneyinstitute.com
Tel: 214 396 4950 Fax: 214 613 2925