CENTERVILLE MEDICAL CENTER
DBA CHUKWUMA OSUAGWU MD PA
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Office (972) 807-6016 Fax (972) 807-6035

CONSENT FOR MEDICAL CARE AND TREATMENT

I understand that my health condition may require diagnosis and treatment. I hereby voluntarily consent to such treatment, services, and procedures as ordered by my doctor, his consultants, associates and his assistants, or his designee. I also understand student nurses and others in professional training programs may be among the individuals who provide care to me.

I authorize Dr. Osuagwu and his assistants/designee to discuss my medical history, diagnosis, treatment and prognosis as provided in the notice of privacy practices. I understand this may include information regarding testing, examination and treatment for HIV/ AIDS related Illness, mental health and drug, alcohol or chemical abuse. I have the right to add anyone or any organization that I do not wish to have my medical information, by requesting such in writing at any time.

I understand there are times when the law allows Dr. Osuagwu and his assistants/designee to release information regardless of whether or not I give my consent as outlined in the notice of privacy practices. For example, Dr. Osuagwu and his assistants/designee may release information to doctors, nurses and others who provide me with health care or are prospective health care providers; to government agencies as authorized by law; to insurance companies or others who are responsible for paying my medical bills; or to a court of law that issues a subpoena or court order. I understand this information may be released either orally or in document form.

I also understand and acknowledge that Texas law provides if any health care worker is exposed to my blood or other bodily fluid, Dr. Osuagwu and his assistants/designee may perform tests, with or without my consent, on my blood or other bodily fluid to determine the presence of any communicable disease, including, but not limited to, Hepatitis, HIV/AIDS and Syphilis. I understand that such testing is necessary to protect those who will be caring for me while I am a patient of Dr. Osuagwu. I understand that the results of the test taken under these circumstances are confidential and do not become a part of my medical record.

I acknowledge that it may be difficult for the physician(s), his/her assistants, or his/her designee to personally communicate with the patient regarding laboratory/diagnostic test results, etc. It is the policy of Dr. Osuagwu's office to leave this information on the patient's telephone answering machine.

NO GUARANTEE: I acknowledge that the practice of medicine is not an exact science and that Dr. Osuagwu has made no guarantees or warranties to me as to the result of treatments or examination.

By signing this consent form you are agreeing that your provider at Centerville Medical Center may request and use your prescription medication history from other healthcare providers and/or third party pharmacy benefit payors for treatment purposes.

It is the policy of Dr. Osuagwu's Office not to release confidential medical information to patient's family members. We cannot discuss your medical condition, or release diagnostic test results to anyone without your consent. I hereby give consent that information regarding my medical condition, including laboratory and diagnostic test results can be given to:

a. _____ Relationship _____

b. _____ Relationship _____

c. _____ Relationship _____

I agree with the above conditions.

Signature of Patient/Legally Authorized Representative	Relationship	Date