



## CONSENT FOR MEDICAL CARE AND TREATMENT

### CONSENT FOR ALTERNATE COMMUNICATION

I understand that I may have a medical condition that could require examination, diagnosis and treatment and other medical services which may include x-rays, laboratory procedures, tests and medications. I do hereby voluntarily consent to such examination, diagnosis, treatment, and other medical services, and procedures that may be recommended under the general and specific instructions of the physicians of Dallas Nephrology Associates, their assistants, nurses or designees. I acknowledge that the practice of medicine is not an exact science and that the physicians of Dallas Nephrology Associates have made no guarantees to me as to the result of examination, diagnosis, treatment or other medical services.

Dallas Nephrology Associates recognizes the importance and significance of maintaining confidentiality of information regarding a patient's medical condition. We also want to provide our patients timely communication as to laboratory/diagnostic test results from either Dallas Nephrology Associates' in house laboratory or any other laboratory and other patient medical information. We understand that because of the patient's schedules and our office schedules, personal communication may sometimes be difficult. Dallas Nephrology Associates' policy is not to leave messages regarding sensitive medical information with unauthorized third parties. However, acknowledging that it may be difficult for the physician/physician's staff to personally communicate with the patient regarding laboratory/diagnostic test results, or patient medical information, it is the policy of Dallas Nephrology Associates to leave such information on the patient's telephone answering machine unless you indicate that you do not consent to leaving such messages on your answering machine.

I consent  I do not consent

If the physician/physician's staff cannot reach the patient at the home, cell or business telephone, it is the policy of Dallas Nephrology Associates that a message will be left with the person that answers the telephone to advise the patient to return the phone call unless you indicate you do not consent.

I consent  I do not consent

It is the policy of Dallas Nephrology Associates not to release confidential medical information to patient's family members unless the patient consents to the release. We will not discuss your medical condition, or release diagnostic test results to anyone without your consent. **Information regarding my medical condition, including laboratory and diagnostic test results, can be given to the following designated persons**

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(Names of Designated Person)

I consent  I do not consent

It is the policy of Dallas Nephrology Associates to participate in or support clinical research designed to use patient data to improve diagnosis and treatment of medical illnesses and to identify potential study subjects for clinical research; such research support may include the review or disclosure of a patient's medical records to research staff unless you indicate you do not consent.

I consent  I do not consent

It is the policy of Dallas Nephrology Associates to send appointment reminders to our patients, either by telephone, e-mail or reminder cards unless you indicate you do not consent.

I consent  I do not consent

At some of its medical offices, Dallas Nephrology Associates collaborates with nursing and medical school teaching programs enabling students as well as physicians in residency and fellowship programs to observe patient care, and if permitted by a physician based upon their level of training and experience to assist the office medical personnel in the delivery of medical services under the supervision and direction of a Dallas Nephrology Associates physician unless you indicate you do not consent.

I consent                       I do not consent

Dallas Nephrology Associates physicians allow future students and those involved in current teaching programs to accompany them at some of its medical offices and on hospital and dialysis rounding with patient consent and appropriate permission from those facilities.

I consent                       I do not consent

All of the foregoing consents are continuing in nature during the entire course of my care unless specifically revoked by me.

Print Name of Patient \_\_\_\_\_ Date \_\_\_\_\_

Signature of Patient \_\_\_\_\_ Date \_\_\_\_\_

If you have a Personal Representative /Guardian who has been given authority to act on your behalf, please provide us with that name and contact information.

\_\_\_\_\_  
Personal Representative/Guardian                      Telephone No.

\_\_\_\_\_  
Witness                      Date

*(Any individual consent or this entire consent can be revoked at any time upon receipt of your written request.)*