LABORATORY SERVICES

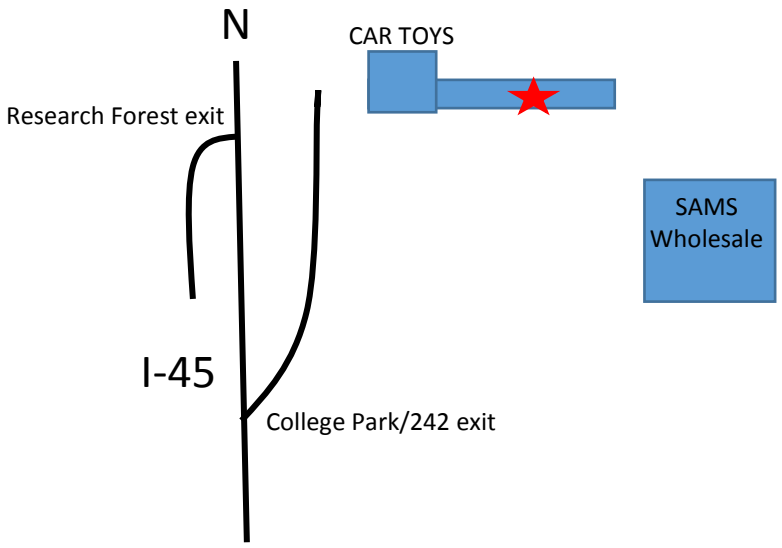
SynergenX Health Clinic Laboratory Draw is completed in the office visit. No appointment is necessary. Please bring a copy of your insurance card with you if possible or call ahead (281) 362-5580 and give your insurance information to our front desk coordinator. Listed below are some basic instructions for preparation for your lab test. If you have questions, please contact our front office at (281) 362-5580 information. Our Office hours are as follows:

M- 7:00 am – 4:00 pm
T- 8:00 am – 5 pm
W- 9:00 am – 7:00 pm
Th- 8:00 am – 5:00 pm
Fr- 8:00 am – 5:00 pm
Sa- 8:00 am – 12:00 pm

If you are here for **Men's Hormone Replacement Therapy** please see below for instructions:
Must have labs completed before 10:00 am and must be fasting (nothing to eat, drink, chew etc… except can have water). You must also have **two blood draws** to show if levels are low before we start treatment.

If you are here for **Women's Hormone Replacement Therapy** please see below for instructions:
Must be fasting (nothing to eat, drink, chew etc… except can have water).

If you are here for **Weight Loss** please see below for instructions:
Must be fasting (nothing to eat, drink, chew etc… except can have water).



SynergenX Health
19073 I-45 South Suite 145
Shenandoah, TX 77385
Phone: (281) 362-5580
Fax: (281) 719-5175

SYNERGENX
HEALTH & WELLNESS CLINIC

19073 I-45 South, Suite #145, Shenandoah, TX 77385
(281) 362-5580 FAX: (281) 719-5175

WELCOME TO SYNERGENX HEALTH CLINIC!

Through our desire to provide you with the most focused and personalized healthcare experience, we would like to understand the primary reasons that have brought you to see us today. Please take a few moments to identify which of the following you are hoping to achieve through your experience at SynergenX Health Clinic.

(Please assign a numerical value from 1-7 to each goal in order of importance.)

_____ Management of a Chronic Illness
_____ Physical Stamina & Endurance
_____ Increased Libido
_____ Weight Loss
_____ Improved Mental Clarity
_____ Improved Quality of Life
_____ Improved Energy

SynergenX Health & Wellness Clinic		Patient Registration Form
Name *(Last, First, M.I.):* ☐ M ☐ F		**DOB:**
Age:	**E-Mail Address:**	
Address:		
City:	**State:**	**Zip:**
Home Phone Number: ( )		**Cell Phone Number:** ( )
May we send you a text message reminder the day before your appointment? ☐ YES ☐ NO		
How did you hear about SynergenX Health Clinic? ☐ Billboard ☐ Coupon ☐ Direct Mailing ☐ Employee ☐ Internet ☐ M.D./Doctor ☐ Other ☐ Newspaper ☐ Patient/Friend ☐ Radio ☐ Walk-In ☐ Rheumatic Fever ☐ Magazine		
Did someone Refer you to SynergenX Health Clinic?	**Which Doctor, if any, referred you?**	

INSURANCE POLICY HOLDER INFORMATION (If different than above)	
Patient Name: (Last, First, MI)	
Date of Birth:	Social Security Number (SSN): - -
Employer:	Preferred Phone: ( ) -
Insurance Name:	
Insurance ID #:	Group / Policy #:
Guarantor Name: (Last, First, MI)	
Relationship: (self / spouse / other)	
Date of Birth: (if different from above)	Social Security Number (SSN): - -

Weight Management Consent Form

I_____ authorize SynergenX Health Clinic providers and whomever they designate as their assistants, to help me in my weight reduction efforts. I understand that my program may consist of a balanced deficit diet, a regular exercise program, instruction in behavior modification techniques, and may involve the use of appetite suppressant medications. Other treatment options may include a very low calorie diet, or a protein supplemented diet. I further understand that if appetite suppressants are used, they may be used for durations exceeding those recommended in the medication package insert. It has been explained to me that these medications have been used safely and successfully in private medical practices as well as in academic centers for periods exceeding those recommended in the product literature.

I understand that any medical treatment may involve risks as well as the proposed benefits. I also understand that there are certain health risks associated with remaining overweight or obese. Risks of this program may include but are not limited to nervousness, sleeplessness, headaches, dry mouth, gastrointestinal disturbances, weakness, tiredness, psychological problems, high blood pressure, rapid heartbeat, and heart irregularities. These and other possible risks could, on occasion, be serious or even fatal.

Risks associated with remaining overweight are tendencies to high blood pressure, diabetes, heart attack and heart disease, arthritis of the joints including hips, knees, feet and back, sleep apnea, and sudden death. I understand that these risks may be modest if I am not significantly overweight, but will increase with additional weight gain.

I understand that much of the success of the program will depend on my efforts and that there are no guarantees or assurances that the program will be successful. I also understand that obesity may be a chronic, life-long condition that may require changes in eating habits and permanent changes in behavior to be treated successfully.

I have read and fully understand this consent form and 1realize I should not sign this form if all items have not been explained to me. My questions have been answered to my complete satisfaction. I have been urged and have been given all the time I need to read and understand this form.

If you have any questions regarding the risks or hazards of the proposed treatment, or any questions whatsoever concern the proposed treatment or other possible treatments, ask your doctor now before signing this consent form.

Financial Policy

Thank you for selecting SynergenX Health Clinic for your health care needs. We are honored to be a service to you and your family. This is to inform you of our billing requirements and our financial policy. Please be advised that payment for all services will be due at the time services are rendered, unless prior arrangements have been made.

I agree that should this account be referred to an agency or an attorney for collection, I will be responsible for all collection costs, attorney's fees and court cost.

Consent to Have Blood Drawn For Treatment/Testing

Please initial one of the following:

_____I authorize the medical staff at SynergenX to obtain a blood sample for the purpose of determining specific laboratory test levels.
_____I have received labs within one year and will bring a copy before my next visit to have filed in my records at the SynergenX Clinic.
_____I have not had labs drawn within one year but will schedule an appointment with my primary care physician to have these lab test performed. I will bring a copy of this lab as soon as possible to be filed in my records.
_____I am 35 years old or younger and I have no history of any medical illness. I do not have medical insurance so I decline to have lab test taken at this time. I understand the risks and accept responsibility for any medical problems, including fatal illnesses that may arise from taking HCG, Adipex, or any other weight loss supplements.

Consent to Obtain Medication History

I authorize the SynergenX Health Clinic to obtain my medication history from the e-prescribing network system. This information will be used by the providers of the SynergenX Health Clinic for the sole purpose of keeping a current and accurate listing of medications.

Supplement Key Chain Pill Fob

We may provide a supplement key chain pill container as part of a new patient starter kit or as separately sold item. This container is not approved or appropriate for storing controlled substances, such as prescribed medications. All prescribed medications must remain in their originally labeled bottle.

Patient Statement of Understanding

I have read and fully understand the above information related to insurance and participation in SynergenX Health Clinics® weight loss program. I have also had the opportunity to ask questions regarding these issues. I am aware that I will receive an appropriate receipt of payment for my personal use as I see fit to do so. I understand the specifics of these receipts and limitations as described in this document. I accept these specific policy rules.

Printed Name:	Date:
Patient Signature:	

Provider

"I have reviewed each of the foregoing with the patient, including discussing the potential risks and benefits of treatment, the patient's complete past medical and health history and relevant family medical history. The patient has been provided the opportunity to ask questions concerning the risks, benefits, and alternatives to treatment, and desires to {Circle one} commence / refuse treatment."

Provider Signature:	Date:

SYNERGENX
HEALTH & WELLNESS CLINIC

19073 I-45 South, Suite #145, Shenandoah TX, 77385
(281) 362-5580 Fax: (281) 719-5175

*****CLINICAL USE ONLY*****		
Date:	**MRN:**	
Name: (Last, First)		
Height:	**Weight:**	**BMI:**
B/P:	**Pulse:**	
Waist Circumference:		

PLEASE PLACE A CHECK IN THE BOXES, IN RELATION TO YOUR HISTORY AND SYMPTOMS

Chief Complaint / Reason for visit:

☐ Fatigue ☐ Decreased Sex Drive (low Libido) ☐ Erectile Dysfunction ☐ Decreased Muscle Mass ☐ Weight Concerns ☐ Mood Concerns

Symptoms began: _____months / years ago.

Severity of Symptoms: Mild Mild to Moderate Moderate Severe

Any Modifying Factors: _____ Timing of Symptoms: _____

Current Weight: _____ Goal Weight: _____ When was the last time (if ever) you were at that weight? _____

Patient Health History

Have you had Comprehensive physical exam within the last 12 months? ☐ Yes ☐ No
Have you had an EKG in the last 12 months: ☐ Yes ☐ No
If Yes was it normal? ☐ Yes ☐ No

Men Only:
Have you had a prostate exam in the last 12 months? ☐ Yes ☐ No
If Yes was it normal? ☐ Yes ☐ No

Women Only:
How old were you at onset of menstruation?
Date of last menstruation?
How often do you get your period (days)?
Number of pregnancies: Number of live births:
Are you pregnant, trying for pregnancy or breastfeeding? ☐ Yes ☐ No
Heavy Periods, irregularity, spotting, pain, or discharge? ☐ Yes ☐ No

Allergies to Medications

Medication Name	Reaction

Prescribed Medications & Over-the-Counter drugs, dietary Supplements (including vitamins, inhalers etc)

Medication Name	Strength	Frequency

Androgen Deficiency Review of Systems

Check which of these symptoms are troublesome and have persisted over time

Primary Symptoms

- ☐ Decreased Sexual Desire (Low Libido)
- ☐ Decreased Spontaneous Erections
- ☐ Breast Discomfort
- ☐ Breast Enlargement (Gynecomastia)
- ☐ Testes that are less than 2.5 cm in length
- ☐ Unusual Sweating
- ☐ Noticeable decreased in testicular size
- ☐ Hot Flashes
- ☐ Loss of axillary or pubic hair

Secondary Symptoms

- ☐ Weight Gain
- ☐ Lack of Energy
- ☐ Fall Asleep After Dinner
- ☐ Sleep Disturbances
- ☐ Lost Height
- ☐ Decreased Enjoyment of Life
- ☐ Decreased Muscle Mass
- ☐ Recent Deterioration of Work Performance
- ☐ Decreased Ability to Play Sports
- ☐ Decreased Strength/Energy
- ☐ Sad, Grumpy or Moodiness
- ☐ Problem with Memory/Concentration

Adrenals

Check which of these symptoms are troublesome and have persisted over time

Cortisol Excess

- ☐ Sleep Disturbances
- ☐ Heart Palpitations
- ☐ Bone Loss
- ☐ Headaches
- ☐ Fatigue
- ☐ Weight Gain – Waist
- ☐ Cold Body Temperature
- ☐ Loss of Muscle Mass
- ☐ Sugar Cravings
- ☐ Thinning Skin
- ☐ Elevated Triglycerides
- ☐ Decreased Sexual Desire (Low Libido)
- ☐ Hair Loss
- ☐ Stress
- ☐ Increased Facial Hair
- ☐ Increased Body Hair
- ☐ Acne
- ☐ Nervous
- ☐ Breast Cancer
- ☐ Irritable
- ☐ Anxious
- ☐ Memory Lapses

Cortisol Deficiency

- ☐ Fatigue
- ☐ Sugar Craving
- ☐ Allergies
- ☐ Chemical Sensitivity
- ☐ Stress
- ☐ Cold Body Temperature
- ☐ Irritable
- ☐ Arthritis
- ☐ Heart Palpitations
- ☐ Aches/Pains

Thyroid

Check which of these symptoms are troublesome and have persisted over time

Thyroid Excess

- ☐ Heat Intolerance
- ☐ Voice has become hoarse
- ☐ Heart Palpitations
- ☐ Weight Loss
- ☐ Tremors/Shakiness
- ☐ Diarrhea
- ☐ Nervousness/Anxious/Panic Attacks
- ☐ Muscle Weakness
- ☐ Difficulty Conceiving/Infertility
- ☐ Coarse Dry Skin
- ☐ Insomnia

Thyroid Deficiency

- ☐ Cold Intolerance
- ☐ Constipation
- ☐ Fatigued/Weakness
- ☐ Unexplained Weight Gain
- ☐ Inability to Lose Weight
- ☐ Stress
- ☐ Cold Body Temperature
- ☐ Irritable
- ☐ Lack of Motivation
- ☐ Muscle Cramps
- ☐ Aches/Pains

Sexual Function

Check which of these symptoms are troublesome and have persisted over time

- ☐ Loss of morning erections
- ☐ Loss of spontaneous erections
- ☐ Trouble getting an erection
- ☐ Trouble keeping an erection
- ☐ Decreased sexual desire (low libido)
- ☐ Premature ejaculation
- ☐ Delayed ejaculation

Past Medical History ☐ NONE

☐ Prior Hormone Replacement Therapy
_____
☐ Sleep Apnea: _____
☐ Snoring
☐ Chronic Kidney Disease
☐ Abnormal Liver function
☐ Heart Disease: _____
☐ High Blood Pressure: _____
☐ High Cholesterol _____
☐ Peripheral artery disease
☐ Chronic Lymph node enlargement
☐ Inability to father children despite unprotected sexual relations > 1 year
☐ COPD
☐ Insomnia

☐ Diabetes I _____
☐ Diabetes II _____
☐ Hypothyroidism
☐ Enlarged Thyroid
☐ Enlarged Prostate
☐ Hx of prostate cancer
☐ Hypogonadism
☐ Depression
_____
☐ Anxiety
☐ HIV
☐ Mumps
☐ Acid Reflux
☐ Gout
☐ Headaches (frequent)

☐ Anemia
☐ Hemochromatosis
☐ Bleeding disorder: _____
☐ Obesity
☐ Cottonseed Allergy
☐ History of Seizures
☐ Cancer _____
☐ Cardiovascular Disease
  ☐ Blood Clot (DVT/Pulmonary Emboli)
  ☐ Chest Pain
  ☐ Heart Attack
  ☐ Heart Failure (CHF)
  ☐ Stroke
☐ Other: _____
☐ Other: _____

FOR WOMEN ONLY

☐ Endometriosis
☐ Fibroids
☐ Polycystic Ovarian Disease (PCOS)

Past Surgical History ☐ No history of genitourinary surgery

MEN	WOMEN
☐ Vasectomy ☐ Other urinary system surgeries: _____ ☐ Other surgeries: _____	☐ Hysterectomy _____Partial _____Total ☐ Other urinary system surgeries: _____ ☐ Other surgeries: _____

Family History ☐ Negative

☐ Family history of prostate cancer
  ☐ First degree relative _____
☐ Family history of Cardiovascular Disease
  ☐ Heart Attack ☐ Stroke
☐ Family history of endocrine disease
  ☐ Diabetes ☐ Hypothyroidism ☐ Delayed Puberty ☐ Reproductive disorder
☐ Family history of Breast Cancer
☐ Family history of Ovarian cancer
☐ Other

Social History

Exercise

How often are you physically active for 20 minutes or longer?

☐ Never ☐ 1-2 x/week ☐ 3-4 x/week ☐ >5 x/week

Which type(s) of exercise do you do? (check all that apply)

☐ Walking ☐ Running ☐ Weights ☐ Other _____

Do you have any barriers that limit your ability to safely exercise? ☐ Yes ☐ No

Please check all that apply:

☐ Work ☐ Family ☐ Energy level ☐ Medical Condition ☐ Pain ☐ Motivation ☐ Other _____

Caffeine

Rank your caffeine intake: ☐ High ☐ Medium ☐ Low ☐ None

What do typically drink during the day?

☐ Water ☐ Juice ☐ Tea ☐ Cola ☐ Diet Cola ☐ Coffee ☐ Other:_____

How many cups/cans per day? _____

Alcohol

Do you drink alcohol? ☐ Yes ☐ No

If yes, what kind? ☐ Beer ☐ Liquor ☐ Wine

How many drinks per week? ☐ 0 ☐ 1-3 ☐ 4-6 ☐ >6

Tobacco

Do you use tobacco? ☐ Yes ☐ No

☐ Cigarettes – pks./day: _____ How many Years? _____

Drugs

Do you currently use recreational or street drugs? ☐ Yes ☐ No

Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No

Sex

Are you sexually active? ☐ Yes ☐ No

If yes, are you trying for a pregnancy? ☐ Yes ☐ No

Do you desire more children? ☐ Yes ☐ No

If not trying for a pregnancy list contraceptive or barrier method are you using:

Diet

Are you dieting? ☐ Yes ☐ No

If yes, are you on a physician prescribed medical diet? ☐ Yes ☐ No

How many meals do you eat on an average day?

Rank your salt intake ☐ High ☐ Medium ☐ Low

Rank your fat intake ☐ High ☐ Medium ☐ Low

Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Occupation:

Please check the appropriate column for each of the following questions:					
	Never	Rarely	Sometimes	Often	Almost Always
Does your family eat meals together?					
Do you read the food labels/nutritional information when you shop for food?					
Does your nutritional information influence your decision to buy/eat certain foods?					
Do you eat in front of a TV?					
Do you eat with others?					
Do you eat when you are stressed?					
Do you eat when you are anxious?					
Do you eat when you are lonely?					
Do you eat when you are not hungry?					
Do you eat when you are bored?					

Lifestyle

How many hours do you typically sleep at night? _____

How long does it typically take you to fall asleep? _____

How many times, on average, do you wake up once you fall asleep? _____

Do you wake up most mornings feeling well rested? ☐ **Yes** ☐ **No**

Has anyone ever told you that you snore? ☐ **Yes** ☐ **No**

Please use the scale below to answer the next several questions in relation to your energy level while performing the following activities.

0 = no chance of dozing 2 = moderate chance of dozing

1= slight chance of dozing 3 = high chance of dozing

Sitting and reading _____

Watching TV _____

Sitting inactive in public place (e.g. theatre or meeting) _____

As a passenger in a car for an hour without a break _____

Lying down to rest in the afternoon when circumstances permit _____

Sitting and talking to someone _____

Sitting quietly after a lunch without alcohol _____

In a car, while stopped for aa few minutes in traffic _____

TOTAL (for staff use only): _____

Weight History
1. What is the main reason you decided to lose weight?
2. When did you begin gaining excess weight (give reasons if known)?
3. What do you think is the main cause of your weight problems?
4. Describe your previous attempts at weight loss or previous diets you have followed. Give dates and results if possible.
5. Is your spouse, fiancé, or partner overweight?
6. How often do you dine out? What restaurants do you frequent? What types of food do you eat there?
7. List any food allergies:
8. What foods do you avoid?
9. What foods do you crave?
10. Do you awaken hungry during the night?
11. What are your worst food habits?
12. What are your snack habits?
13. Rate your body from 1 to 10. How would you describe your body?
14. If you could change one thing about your body, what would it be?
15. What do you feel will be your obstacle(s) to successful weight loss?
16. What is your typical breakfast? What time? Where? With whom?
17. What is your typical lunch? What time? Where? With whom?
18. What is your typical dinner? What time? Where? With whom?
19. Add any additional comments you think would be helpful to the doctor.

Accuracy Agreement	
I hereby agree that the information contained in this medical history is accurate to the best of my knowledge.	
Signature:	Date:

Thank You.

This information will assist us in establishing your medical history and identifying problem areas. Thank you for your time and patience in completing this form.

*****SynergenX Clinician Use Only*****

Physical Exam: _____

Impression / Diagnosis:

- ☐ Hypogonadism
- ☐ Fatigue
- ☐ Muscle weakness
- ☐ Hypo-active sexual desire d/o(low libido)
- ☐ Mild cognitive impairment(memory)
- ☐ Obstructive Sleep Apnea
- ☐ Menopause/perimenopause d/o
- ☐ Elevated PSA
- ☐ Abnormal EKG
- ☐ Elevated B/P
- ☐ Obesity, Unspec
- ☐ Metabolic Syndrome
- ☐ Insomnia
- ☐ Hypothyriodism
- ☐ Dietary Counseling and surveillance
- ☐ Nutritional Deficiency, Unspec
- ☐ Vitamin Deficiency, Unspec
- ☐ Deficiency of other specified B group vit(B12)
- ☐ Deficiency of other vit (vit C/vitD)
- ☐
- ☐ Other: _____

Lab results: _____ EKG Results: _____

Treatment: Testosterone Injection Today: _____ B12 Injection Today: _____

Labs: TT SHBG PSA TSH E2 Prl FSH LH CBC CMP / Vit D Vit B12 DHEA-S HGH Lipid panel

Plan: KCNP KCNONTX (T WNL) NONTX2 (T&cFT WNL) KC150 (TT<150) KCNPNOSHOT (T low, but no inj) NPFERT3 (T low, wants fertility)

SynergenX Health & Wellness Clinic HIPPA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment, and healthcare operations, and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Protected Health Information, or PHI, is information about you, including demographic information, that
may identify you and that relates to your past, present, or future physical or mental health or condition and related healthcare services.

Uses and Disclosures of Protected Health Information
Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operations of the physicians practice, and any other use required by law.

Treatment
We will only use and disclose your protected health information to provide, coordinate, or manage your health care and related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides you care to you, or provide it to a physician whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment
Your protected health information will be used as needed to obtain payment for your health care services.

Healthcare Operations
We may use or disclose, as needed, your protected health information In order to support the business activities of your physician's practice. These activities include but are not limited to quality assessment, employee review, training of medical students, and licensing. For example, we may call you be name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments.

We may use or disclose your protected health information in the following situations without your authorization: as required by law, public health issues, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity, and national security. Under the law, we must also make disclosures to you, and when required by the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted & Required Uses and Disclosures
Disclosures will be made only with your authorization or opportunity to object unless required by law. You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Individual Rights:

1. **You have the right to inspect and receive a copy of your protected health information**. Our practice will accept such requests in writing. Under federal law, however, you may not inspect or receive a copy of the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

2. **You have the right to request a restriction on the disclosure of your protected health information**. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends whom may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of our protected health information, your health information will not be restricted. You then have the right to use another healthcare professional.

3. **You have the right to request to receive confidential communications from us by an alternative means or at an alternative location**.

4. **You have the right to obtain a paper copy of this notice from us**.

5. **You have the right to receive an accounting of certain disclosure we have made, if any, of your protected health information**. We reserve the right to change the terms of this notice and will post any changes in our waiting areas. You then have the right to object as provided in this notice.

Complaints
You may file any complaints with our Privacy Officer, Sheila Jumper, at (281) 970-5900, or with the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. We will not retaliate against you for filing a complaint.

SynergenX Health & Wellness Receipt of Notice of Privacy Practices	MRN:

SynergenX Health Clinics® reserves the right to modify the privacy practices outlined in this notice.
By signing below, I am indicating that I have received a copy of the Notice of Privacy practices for **SynergenX HealthClinics®.**

Printed Name:	Patient Signature:	Date:

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

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: SynergenX Health Clinic
Address 19073 I-45 South, Suite #145
City: Shenandoah State: Texas Zip Code: 77385

Phone: (281) 362-5580 Fax: (281) 719-5175

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name _____
Address _____
City _____ State _____ Zip Code _____

Phone (_____)_____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 reach-ing 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 au-thorization 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 cer-tain 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

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.