WELCOME TO SYNERGENX HEALTH CLINIC!

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
☐ Newspaper ☐ Patient/Friend ☐ Radio ☐ Walk-In ☐ Magazine ☐ Other

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): - -

Men's Hormone Replacement Therapy Consent Form

It is important to SynergenX Health Clinic that you understand the risks and benefits associated with Testosterone Replacement Therapy (TRT) before beginning or continuing treatment. TRT is not a new area of medicine, and is used for the treatment of a medical condition known as hypogonadism in males. You should also be aware of alternatives to TRT, including not receiving TRT treatment. It is important that you consider the information provided and discuss the information carefully with your provider. Be sure that you are doing what is right for you. If you are unsure, then you should refuse and/or discontinue treatment.

The hormones that may be prescribed as part of your treatment may include Progesterone, and Testosterone as well Vitamin D, B12 and other dietary supplements, where indicated. Recommended treatment in some instances may include "off-label" drug use of an approved FDA medication, such as progesterone in men. Testosterone is FDA-approved only for use in men who lack or have low testosterone levels in conjunction with associated symptoms. These symptoms are often related to male andropause, or aging, and may include decreases in energy and motivation, poor concentration or memory, feelings of depression or irritability, sleep disturbances, reduced muscle mass, increased body fat, and reduced sexual desire or libido. These symptoms may be treatable in hypogonadal males utilizing testosterone. The therapeutic objective of TRT is to restore normal testosterone levels, helping to reduce these symptoms. There are a number of potential side effects related to TRT. You should discuss each of these with your medical provider. Side effects may include increased red blood cells, acne, sleep apnea, breast enlargement, testicular atrophy, lowered sperm count, mood swings, injection site reactions such as bleeding, pain, swelling, redness, or infection, increased estrogen production, or fluid retention. TRT is not recommended for patients who have breast or prostate cancer, or who are thinking about becoming parents. You should also be aware that some recent studies have associated TRT with increased risk for adverse cardiovascular events, such as blood clots, heart attacks, or strokes, in certain types of patients. If you have a history of cardiac or urologic problems, your provider may require clearance from your cardiologist or urologist prior to initiating treatment. Each patient's own risks can vary depending upon health history and lifestyle. It is important that you provide an accurate and complete medical history to your provider.

Please tell your provider if you have used alcohol or illicit drugs prior to your treatment visit. You can learn more about potential side effects associated with TRT at www.medwatch.com.

You and your health care provider need to discuss the risks and benefits of treatment before you start or continue treatment.

Patient:

"This is my consent for SynergenX Health Clinic, including any physician, mid-level provider or nurse who works with the SynergenX Health Clinic physicians, to begin treatment for Hormone Replacement Therapy.

_____ I have read and understand that there may be complications arising from or related to treatment as described above, and explained by my treating medical provider. I have had an opportunity to discuss my complete past medical and health history including any serious problems and/or injuries, as well as my family history of diseases and conditions, with my provider. All of my questions concerning the risks, benefits, and alternatives to treatment have been answered. I am satisfied with the answers and desire to commence treatment, knowing the risks and potential side effects involved.

_____ I understand that I will have periodic blood tests to monitor my blood levels of testosterone and I consent to such testing. I understand that the physical exam by my SynergenX provider does NOT replace a full physical exam by my personal physician, and I agree to have my personal physician (not SynergenX Health Clinic) perform a full physical exam including a lipid profile, cholesterol profile, digital rectal exam, and full metabolic panel, not less than annually.

_____ I understand that each patient is different and there are no guarantees as to results obtainable from TRT treatment. TRT is not a cure, and if I stop treatment, symptoms may return or worsen.

_____ I am not currently attempting to father children. If this changes, I will advise my provider at SynergenX immediately.

_____ I do not have and have not been diagnosed with cancer."

Consent to Have Blood Drawn for Treatment/Testing

I authorize the medical staff at SynergenX to obtain a blood sample for the purpose of determining specific laboratory test levels.

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.

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:

AUA SYMPTOM SCORE (AUASS) AND QUALITY OF LIFE (QOL)

NAME (Last, First): **DOB:** **TODAY'S DATE:**

(Circle One Number on Each Line)	Not at All	Less Than 1 Time in 5	Less Than Half the Time	About Half the Time	More Than Half the Time	Almost Always
Over the past month or so, how often have you had a sensation of not emptying your bladder completely after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you had to urinate again less than two hours after you finished urinating?	0	1	2	3	4	5
During the past month or so, how often have you found you stopped and started again several times when you urinated?	0	1	2	3	4	5
During the past month or so, how often have you found it difficult to postpone urination?	0	1	2	3	4	5
During the past month or so, how often have you had a weak urinary stream?	0	1	2	3	4	5
During the past month or so how often have you had to push or strain to being urination?	0	1	2	3	4	5
	None	1 Time	2 Times	3 Times	4 Times	5 or More Times
Over the past month, how many times per night did you most typically get up to urinate from the time you went to bed at night until the time you got up in the morning?	0	1	2	3	4	5

Add the scores for each number above and write the total in the space below.
TOTAL:_____

SYMPTOM Score: 1-7 (Mild) 8-19 (Moderate) **20-35 (Severe)**

QUALITY OF LIFE (QOL)

	Delighted	Pleased	Mostly Satisfied	Mixed	Mostly Dissatisfied	Unhappy	Terrible
How would you feel in you had to live with your urinary condition the way it is now, no better, no worse, for the rest of your life?	0	1	2	3	4	5	6

SYNERGENX
HEALTH & WELLNESS CLINIC

*****CLINICAL USE ONLY*****			
Date:		**MRN:**	
Name: (Last, First)			
Height:	**Weight:**	**BMI:**	
B/P:		**Pulse:**	
BMI	**PBF**	**ICW**	**ECW**
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: _____

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
- ☐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

History of Cardiac Disorder / Event ☐ NONE	
☐Myocardial infarction	Date:
☐Cerebrovascular accident	Date:
☐Thrombosis / Embolism	Date:
☐Coronary artery bypass graft surgery / CABG	Date:
☐Aortic valve disorder	Date:
☐Mitral Valve Disorder	Date:
☐Endocarditis	Date:
☐Pericarditis	Date:
☐Cardiomyopathy	Date:
☐Cardiac conduction disorder (AV block, Bundle Branch block, Mobitz type II AV)	Date:
☐Cardiac arrhythmia (Atrial fibrillation/flutter, Paroxsymal supraventricular tachycardia, etc.)	Date:
☐ Heart failure (congestive heart failure, etc.)	Date:

Past Medical History ☐ NONE

☐ Prior Hormone Replacement Therapy _____	☐ Diabetes Type I _____	☐Anemia
☐ Sleep Apnea: _____	☐ Diabetes Type II _____	☐ Hemochromatosis
☐ Snoring	☐ Hypothyroidism	☐ Bleeding Disorder: _____
☐ Chronic Kidney Disease	☐ Enlarged Thyroid	☐ Obesity
☐ Abnormal Liver function	☐ Enlarged Prostate	☐ Cottonseed Allergy
☐ Heart Disease: _____	☐ History of prostate cancer	☐ History of Seizures
☐High Blood Pressure: _____	☐ Hypogonadism	☐ Cancer _____
☐ High Cholesterol _____	☐ Depression _____	☐ Cardiovascular Disease
☐ Peripheral artery disease	☐ Anxiety	☐ Blood Clot (DVT/Pulmonary Emboli)
☐ Chronic Lymph node enlargement	☐ HIV	☐ Chest Pain
☐ Inability to father children despite unprotected sexual relations > 1 year	☐ Mumps	☐ Heart Attack
☐ COPD	☐ Acid Reflux	☐ Heart Failure (CHF)
☐ Insomnia	☐ Gout	☐ Stroke
	☐ Headaches (frequent)	☐ 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? _____: _____ 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:

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

Physical Exam:

_____

Impression / Diagnosis:

- ☐ Hypogonadism
- ☐ Fatigue
- ☐ Muscle weakness
- ☐ Low libido (sexual desire)
- ☐ Mild cognitive impairment(memory)
- ☐ Obstructive Sleep Apnea
- ☐ Elevated PSA
- ☐ Abnormal EKG
- ☐ Elevated B/P
- ☐ Other specified B group vit(B12)
- ☐ Metabolic Syndrome
- ☐ Insomnia
- ☐ Hypothyriodism
- ☐ Dietary Counseling and surveillance
- ☐ Nutritional Deficiency, Unspec
- ☐ Overweight
- ☐ Obesity
- ☐ Morbid Obesity
- ☐ Vitamin D Deficiency
- ☐ Other: _____

Testosterone Level: _____ cFT: _____ PSA: _____

WT: _____ BMI: _____ PBF: _____ ICW: _____ ECW: _____

Treatment: Testosterone Injection Today: _____ AUA: _____

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

Plan: SXNP SXNONTX (T WNL) NONTX2 (T&cFT WNL) SX150 (TT<150) SXNPNOSHOT (T low, but no inj)
NPFERT3 (T low, wants fertility)

_____ _____

Provider Signature Date

Financial Responsibility

All professional services rendered are charged to the patient and are due at the time of service unless other arrangements have been made in advance with our business office. Necessary forms will be completed to file for insurance carrier payments.

Please select one of the following payment options:

Assignment of Benefits- Insurance

☐ I hereby assign all medical and surgical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), private insurance and any other health/medical plan to issue payment check(s) directly to SynergenX Health Physician Services, P.L.L.C. for medical services rendered to me and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered ~~by~~ insurance.

Insurance Waiver and Payment Agreement- Self Pay

☐ I have chosen to be self-pay for health care services provided by SynergenX Health Clinic. I have decided to be self-pay even though I may have health insurance that covers these services and waive my right to have a claim submitted to my insurance company on my behalf. I agree to pay for services in the office on the date they are performed.

Authorization to Release Information

I hereby authorize SynergenX Health Physician Services, P.L.L.C to: (1) release any information necessary to insurance carriers regarding my illness and treatments: (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for the period of lifetime. This order will remain in effect until revoked by me in writing.

I have requested medical services from SynergenX Health Physician Services, P.L.L.C on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in full immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient/Responsible Party Signature Date

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® 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 Health®.**		
Printed Name:	Patient Signature:	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.

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

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

_____

Address

_____

City _____ State _____ Zip Code _____

Phone (_____)_____Fax (_____)_____

WHO CAN RECEIVE AND USE THE HEALTH INFORMATION?

Person/Organization Name: SynergenX Health -

_____

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.

- ☐ Initial visit Lab results to include:
  - Total Testosterone
  - SHBG
- ☐ New Patient Lab results to include:
  - Total Testosterone
  - SHBG
  - PSA
  - CBC
- ☐ Most recent Encounter/Plan to include most recent recommended dose given.

- ☐ **All health information**
- ☐ Physician's Orders
- ☐ Progress Notes
- ☐ Pathology Reports
- ☐ History/Physical Exam
- ☐ Patient Allergies
- ☐ Discharge Summary
- ☐ Radiology Reports & Images
- ☐ Past/Present Medications
- ☐ Operation Reports
- ☐ Diagnostic Test Reports
- ☐ Billing Information
- ☐ 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 reaching 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 authorization 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 certain 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**