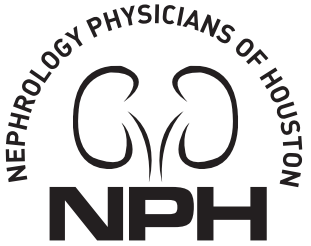
NEPHROLOGY PHYSICIANS OF HOUSTON

NPH



NEPHROLOGY • DIALYSIS • HYPERTENSION • TRANSPLANTATION

(Certified Diplomate of the American Board of Internal Medicine and Nephrology)

(**Board Certified Specialist in Hypertension)

Rafael C. Esquenazi, MD**, FACP, FASN
Mary A. Washington, MD, FACP
Ather R. Khokhar, MD

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I acknowledge receipt of the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____

Name _____ Birthdate _____

X _____ _____

Patient/Guarantor Signature *Date*

AUTHORIZATION AND CONSENT FORM

Consent to Medical Treatment by Physician

I, or authorized representative/legal guardian acting on behalf of the patient, do hereby consent to receiving general medical services, which may include routine diagnostic procedures and such medical treatment as the physician, his/her assistants or his/her designees consider to be necessary in his/her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees have been made to me as to results of treatment of examination at Nephrology Physicians of Houston.

X _____ _____

Patient/Guarantor Signature *Date*

Release of Patient Healthcare Information

I hereby authorize Nephrology Physicians of Houston to release patient healthcare information, in accordance with the policy of the clinic, as is necessary to health care providers to facilitate reimbursement by a health benefit plan or personnel of another health care entity for the sole purpose of providing current continuum of care including, but not limited to fax, mail or electronic submission.

X _____ _____

Patient/Guarantor Signature *Date*

The above authorizations are valid unless you specify otherwise or revoke them in writing.

Authorization to release medical records to family member

I, _____ (patient), AUTHORIZE _____ (family member)

Authorization and Consent

To receive all results of my office visits and lab results to be discussed regarding my health Information effective

THIS AUTHORIZATION WILL REMAIN IN EFFECT UNTIL NOTIFIED BY THE PATIENT OTHERWISE.

_____ _____

Patient Signature Date

1140 Westmont Drive • Suite 320 • Houston, Texas 77015 • Office: 713.637.6320 • Fax: 713.637.0735