Dr. Austin B. Meares

Permission for Diagnostic and Treatment Procedures

I authorize Dr. Meares, his agents or consultants, to perform diagnostic and treatment procedures, which in their judgment may become necessary while at the office of Dr. Meares. If I require specialized and or emergency care, I will be referred to the appropriate medical facility or professional. I understand that a person listed as my emergency contact will be notified if considered necessary by the professional staff of Dr. Meares.

Consent to the use and disclosure of health information for treatment, payment, or healthcare operations.

I further understand that as part of my healthcare, the office of Dr. Meares originates and maintains health records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and any plans for future care treatment. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and information to my bill.
- A means by which a third party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I understand and have been provided with a Notice of Health Information Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Dr. Meares reserves the right to change his notice and practices and prior to implementation will mail or post a copy of any revised notice. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that Dr. Meares is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Dr. Meares has already taken action in reliance thereon.

I fully understand and accept the terms of this consent.

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Signature of patient (or parent/guardian) Date