AUTHORITY TO RELEASE MEDICAL INFORMATION

I hereby authorize the release of the information contained in my medical record to/from

____

____

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I UNDERSTAND THAT MY MEDICAL RECORDS MAY CONTAIN INFORMATION THAT INDICATES THAT I HAVE A COMMUNICABLE OR VENEREAL DISEASE WHICH MAY INCLUDE, BUT IS NOT LIMITED TO, DISEASES SUCH AS HEPATITIS, SYPHILIS, GONORRHEA, OR THE HUMAN IMMUNODEFIIENCY VIRUS, ASLO KNOWN AS ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS).

With this knowledge, I give my consent to the release of all information in my medical records including any information concerning my identity and release provider, its agents, and employees from any liability in connection with the release of information contained therein.

____

Print name Signature Date

1111 Raintree Circle Ste. 200 Allen, TX 75013 214-383-9816

Deborah M. Holubec, M.D., P.A.

I request and consent to the administration of hormones and oral supplements and authorize that these will be prescribed by Deborah M. Holubec, M.D. I acknowledge that there are no guarantees or assurances made with respect to the benefit of hormone supplementation therapy for me.

I understand that I will be in charge of injecting/administering these hormones and supplements prescribed to me. I will conform and comply with the recommended doses and methods of administration.

I understand that initial blood tests will be performed to establish my baseline hormone levels. I agree to comply with results for ongoing testing to assure proper monitoring of my hormone levels. I agree to report to the physicians any adverse reaction or problems that might be related to my hormone therapy. I understand that with hormone supplementation there are possible risks and complications if I do not comply with the recommended dosage.

I have not been promised or guaranteed any specific benefit from the administration of this therapy. I understand that hormone supplementation for rejuvenation purposes is a new specialty and there are no guarantees with respect to the treatment prescribed.

I have been informed that insurance companies and Medicare do not pay for hormone supplementation therapy. I therefore agree to pay for all services, including laboratory and pharmacy charges, myself, with the understanding that I will not be reimbursed by my insurance company.

I have read and understand all of the above consent. I have had other information given to me about hormone supplementation therapy so that I fully understand what I am signing and herby request and consent to treatment using hormone supplementation therapy.

Patient Signature ________________________________ Date ___________

Physician Signature ______________________________ Date ___________

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Name: ____

Address: ____

____
City State Zip

SS#: __________________________ **DOB:** _______________

Home phone: __________________ **Work:** _______________

Cell: __________________________ **Marital Status:** _________

Employer/Occupation: ________________________________

Emp. Address: _______________________________________

Referring Doctor: _____________________________________

Emergency Contact Info (please list the nearest relative or friend)

Name: _______________________ **Phone:** _________________

Relationship: ____

_____________________________ _______________

Signature **Date**

_High blood pressure
_Heart disease
_Angina
_Chest pain
_Irregular heartbeat
_Rheumatic fever
_Mitral Valve Prolapse
_Stroke
_Easy bruising
_Hemophilia
_Bleeding tendency
_Arthritis
_Anemia
_Neck pain/Stiffness
_Thyroid disease
_Mental illness
_Migraine headaches
_Fainting
_Seizure disorder

_Blood transfusion
_Leg cramps/pain
_Varicose vein
_Chemical dependency
_Diabetes
_HIV
_Liver Disease
_Cataracts
_Multiple sclerosis
_Hepatitis
_Vision disorder
_Jaundice
_Back injury
_Neck injury
_Herniated disc
_Steroid use
_Ulcer
_Frequent heartburn
_Hiatal hernia

_Cancer
_Chemotherapy
_Glaucoma
_TB
_Sinusitis
_Bronchitis
_Shortness of breath
_False teeth/caps
_Hoarseness
_Recent cold
_Asthma
_Motion sickness
_Loose teeth
_Sexual transmitted disease
_Emphysema
_Chronic cough
_TMJ

_Tobacco Amount: _____________ Packs/day for ______ years
_Alcohol Amount: ____________________________________
_Street/recreational
Drugs: Types: ____________________________________

Are your immunizations current? __Yes __No

Problems with anesthesia: _Yes _ No
__High temperature __Muscle Soreness
__Allergic reaction __Jaundice __Headache
__Delayed awakening __Prolonged weakness
__Nausea/Vomiting __Excessive bleeding
__Difficulty with breathing tube

List any medical problems not listed above:

____

____

List any previous surgeries:

____

____

List any Allergies: Name Reaction

____

____

____

Current medications: Name Dose Schedule

____

____

____

____

Highest level of education: _________________________________ Height _______________ Weight __________________

Chief complaint/Reason for visit:

____

Do you have any cultural/religious practices that will impact your health care? __Yes __No If yes, please explain:

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Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient of Personal Representative Date

Name of Guardian/Representative Date

Relation to Patient

Witness Date

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