3270 Joe Battle, Suite #360
El Paso, TX 79938

Phone: 915.351.9000
Fax: 915.351.9041

1. **CONSENT TO TREAT**: I hereby consent to permit Dr. Anh Lee to render medical services and counsel to me. I authorize the release of any medical information necessary for my medical treatment.

2. **NOTICE OF PRIVACY PRACTICES**. I have been presented with a copy of the Notice of Privacy Practices for Dr. Lee detailing how my health information may be used and disclosed as permitted under federal and state law, and outlining my rights regarding my health information.

3. **RESPONSIBILITY FOR PAYMENT**: I authorize the release of any medical information necessary to process my insurance claims. I authorize payment directly to my medical doctor for services described on any claim forms filed on my behalf.
   ****I will be fully responsible for all charges not paid by my insurance company****

4. **PRESCRIPTION HISTORY CONSENT:** We are utilizing Escribe and will be reviewing your prescription history. I authorize Dr. Lee to obtain my prescription history.

I acknowledge that I have read and fully understand the above information and have no other questions.

_____
PATIENT NAME – Print (Please print name of parent or legal guardian if minor)

_____ _____
PATIENT SIGNATURE – Signature of parent or legal guardian **DATE**

Adopted: 10/15