RED RIVER FAMILY PRACTICE, LLP

Michael E. Killian, MD Cynthia Brinson, MD J. Eric Lambeth, MD
Gary L. Werntz, MD Mary Bartz, MD Steven B. Hutto, MD

Patient Consent Form
Regarding Use and Disclosure of Health Information
Required by Federal Law

I understand that some of my health information may be used and/or disclosed by Red River Family Practice, LLP to carry out treatment, payment, or health care operations, and that foe a more complete description of such uses and disclosures., I should refer to your privacy notice entitled, "notice of Privacy Practices." I understand that I may review this privacy notice any time prior to signing this form.

I understand that over time your privacy practices may need to change in accordance with law, and if I wish to obtain a copy of the notice as revised, I can call your office to obtain such a copy.

I understand that I may request restrictions on how my information is used or disclosed to carry out treatment, payment or health care operations, and that I can also revoke this consent in writing, but only to the extent that your practice has not taken action in reliance thereon.

I understand for my protection, my requests to amend my health information or to access my medical records must be made in writing.

Signature: _____ Date: _____

Please return Forms one of the following ways:

Bring in with you to your appointment

Email: redriverfamily6@gmail.com

Fax: 512.476.5611 Attn: New Patient Information/Updates

Mail: Red River Family Practice
900 East 30th Street, Suite 300
Austin, TX 78705