



Name: _____ Age: _____ Weight: _____ Height: _____

Reason for visit: Please place a checkmark by the choices below that apply:

- Skin Cancer/ Mohs Surgery _____
- Skin Check/ Mole Check _____
- Cosmetic Surgery _____
- Cosmetic Non-Surgical (skin care, laser, botox, fillers) _____
- Cyst/ Lipoma/ Wart _____
- Other (Please specify) _____

Unfortunately, skin cancer sometimes occurs in areas where the sun does not shine. We would like to give you the most thorough exam possible. If there are any areas **you do not** want examined please indicate below:

- Back, Chest, Abdomen
- Breast
- Genitalia
- Legs

Additional comments or questions:

Skin Disease History

Have you ever had any of the following skin conditions?

- | | |
|--|---|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> Melanoma (Year(s): _____) |
| <input type="checkbox"/> Basal Cell Skin Cancer (Year(s): _____) | <input type="checkbox"/> Precancerous Moles |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Squamous Cell Skin Cancer (Year(s): _____) |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> None |

Do you wear sunscreen?

- Yes
- No

If yes, what SPF?

Do you tan in a tanning salon?

- Yes
- No

Do you have a Family history of Melanoma?

- Yes **If yes, which relative?** _____
- No



Name: _____

Past Medical History

Do you have any of the following medical conditions?

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation (Irregular Heartbeat)
- Benign prostatic hyperplasia
- Bone Marrow Transplantation
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Hearing Loss
- Hepatitis
- Hypertension
- HIV / AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- None

Past Surgeries

Have you had any surgeries?

- Appendix (Appendectomy)
- Bladder (Cystectomy)
- Breast: Mastectomy (Right Breast)
- Breast: Mastectomy (Left Breast)
- Breast: Mastectomy (Both Breasts)
- Breast: Lumpectomy (Right Breast)
- Breast: Lumpectomy (Left Breast)
- Breast: Lumpectomy (Both Breasts)
- Breast: Breast Biopsy
- Breast: Breast Reduction
- Breast: Breast Implants
- Colon (Colectomy): Colon Cancer Resection
- Colon (Colectomy): Diverticulitis
- Colon (Colectomy): Inflammatory Bowel Disease
- Gallbladder (Cholecystectomy)
- Heart: Stent
- Heart: Mechanical Valve Replacement
- Heart: Biological Valve Replacement
- Heart: Heart Transplant
- Joint Replacement: Knee (Both)
- Joint Replacement: Hip (Right)
- Joint Replacement: Hip (Left)
- Joint Replacement: Knee (Left)
- Joint Replacement: Hip (Both)
- Joint Replacement: Knee (Right)
- Kidney: Kidney Biopsy
- Kidney: Kidney Transplant
- Kidney: Nephrectomy
- Ovaries (Oophorectomy): Endometriosis
- Ovaries (Oophorectomy): Ovarian Cyst
- Ovaries (Oophorectomy): Ovarian Cancer
- Prostate (Prostatectomy): Prostate Cancer
- Prostate (Prostatectomy): Prostate Biopsy
- Prostate (Prostatectomy): TURP
- Skin: Skin Biopsy
- Skin: Basal Cell Carcinoma
- Skin: Squamous Cell Carcinoma
- Skin: Melanoma
- Spleen (Splenectomy)
- Testicles (Orchiectomy)
- Uterus (Hysterectomy): Fibroids
- Uterus (Hysterectomy): Uterine Cancer
- Other _____
- None
- Cosmetic Surgery:** _____
- Cosmetic Procedures:**
 - Botox
 - Fillers: _____
 - Lasers: _____
 - Facials/Peels: _____
- Other: _____



Name: _____

Are you experiencing any of the following today?:

- Chest pain
- Difficulty breathing
- Abdominal pain
- Bloody stool
- Bloody urine
- Immunosuppression
- Autoimmune suppression
- Problems with scarring (hypertrophic or keloid)
- Changing mole
- Cold sores
- Dentures
- Fever or chills
- Unintentional weight loss
- Headaches
- Seizures
- Blurry Vision
- Glasses or contact lenses
- Anxiety
- Depression
- Require walker or wheelchair
- None

Please check if any of the following apply to you:

- Pacemaker
- Defibrillator
- Artificial joints within past two years
- Artificial heart valve
- Premedication prior to procedures
- Allergy to adhesive
- Allergy to topical antibiotic ointments
- Allergy to lidocaine
- Rapid heartbeat with epinephrine
- GI upset with antibiotics
- Blood thinners
- Problems with bleeding
- Pregnant or planning a pregnancy
- West Africa: Travel or contact in last 21 days
- Fever > 100.4 degrees (F)
- Traveled to country with wide spread Ebola in 21 days
- Contact with Ebola patient in last 21 days
- Flu-like symptoms in last 21 days
- None

Smoking Status (check one)

- Current every day smoker
- Current some day smoker
- Former smoker
- Never

Alcohol Status (check one)

- Less than 1 drink per day
- 1-2 drinks per day
- 3 or More drinks per day
- None



Name: _____

Free Prescription Delivery Service

As a free service, Dougherty’s Pharmacy will fulfill and deliver your prescriptions to our office when you are having a procedure performed. If you agree, then expect to get a phone call from Dougherty’s Pharmacy to confirm your insurance information. Applicable copays and deductibles apply.

- Yes, I would like this service
- No, I do not want this service

List all medications you are currently taking (including over-the-counter).
If none, please write none. Please print:

Please list any drug allergies and your reaction.
If none, please write none. Please print:

Other Allergies (Iodine?/ Latex?) _____

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____



CONDITIONS OF ADMISSION

For your convenience, we have consolidated our new patient paperwork into this single document to cover the four affiliated covered entities (“**ACE**”) under HIPAA which comprise our practice: Thornwell H. Parker, III, MD, PA (d/b/a Skin Cancer Consultants), Elevate Medical Spa and Cosmetic Surgery, Dallas Hand Specialists of Dallas, and the Dallas Surgi Center, Inc. (collectively “**The Practice**”)

Patient Financial Responsibility

Although patients are ultimately responsible for all charges, as a courtesy, assignment is accepted for most insurance carriers. Applicable estimated copays and deductibles are to be paid at the time of service, as well as uncovered or cosmetic procedures. Some operations/procedures may incur charges for any professional services rendered in The Practice.

Assignment of insurance Benefits and Financial Agreement:

The below signed irrevocably assigns and transfers to the center the Contract Rights, and orders and directs such insurer(s) specified on the registration to pay all monies due or to become due hereunder directly to The Practice. The Practice has irrevocably constituted power, to collect and settle any claim under the Contract Rights as insured without further notice or approval of insured and to endorse in the name of insured any check or other instrument for payment of monies hereunder. If the insured receives monies direct from the insurer, same shall be held in trust for and immediately transferred to The Practice for amount due. This assignment is irrevocable until full and complete payment of all monies due The Practice from this event of admission or otherwise. Money received by The Practice from insurer(s) or other third party sources, less the expense in procuring same, shall be deducted from the principal amount due for services rendered Patient. It is the policy of The Practice to comply with all Federal, State, and Department of Insurance regulations related to collection of co-pays and deductibles. You may be responsible for higher co-pays and deductibles. The Practice may or may not be in-network for your insurance. If your insurance company does not pay the amount within 90 days, you will be responsible for the payment in full. We do not determine payment of a claim, the insurance company does. Please contact your insurance company for any questions regarding your claims. Any deviation from this standard procedure must have arrangements made in advance.

Medicare Assignment:

I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf.

Professional Services Agreement:

To the extent that fees for professional services rendered to the patient are payable, the undersigned hereby assigns to said physicians and authorizes payment directly to said physicians all insurance benefits, including major medical, for professional services rendered to the patient.

Patient Rights/Responsibilities:

I acknowledge that I have been given a copy of the Patient Rights and Responsibilities at time of admission.



Name: _____

Personal Valuables:

The Practice will make its best effort to protect Patient valuables but will not be responsible for any loss.

Physician Disclosure of Ownership:

Pursuant to Texas Law please note that Dr. Thornwell H. Parker III, M.D. has financial agreements with Dallas Surgi Center, Inc., one of the ACE. If you are referred to this entity, Dr. Thornwell H. Parker III, M.D. will receive direct remuneration. If you have any questions regarding this paragraph, please discuss it with Dr. Thornwell H. Parker III, M.D. directly.

Authorization for Release of Information:

The Practice is authorized to furnish from the patient’s record requested information or excerpts to the referring physician, primary care physician and to any insurance company or third party payer for the purpose of obtaining payment of the account of The Practice or any physician for services provided to the patient. The Practice is authorized to release information from my medical record to any health care facility to which I may be transferred.

Verification of Third Party Benefits:

The below signed authorizes the verification of third party benefits, any item referenced herein, statements and other data obtained from Patient and/or below signed and all other persons pertaining to the respective credit and financial responsibilities, understanding that an investigative consumer report may be made whereby information is obtained through personal interviews with third parties. The Practice or its contractor is authorized to investigate all information given by the below signed verbally and other such areas as reasonable connected with The Practice efforts in collection, now or in the future. Below signed hereby releases from liability, indemnifies from loss and specifically authorizes any requesting entity to make such disclosure to The Practice or its agents as they deem necessary in considering and verifying any application for credit. Below signed acknowledges that a complete and accurate disclosure of the nature and scope of the investigation will be given upon written request and hereby declares that all information furnished hereon and subsequently is and shall be true.

Patient’s Signature **Date**

Witness **Date**

OR Guardian Signature | Relationship | Date



Name: _____

Newsletter and Specials

Would you like to receive periodic emails from The Practice?

Skin Cancer Consultants

- Yes, I give permission to email me specials/info
- No, I do not give permission to email me specials/info

Elevate Medical Spa & Cosmetic Surgery

- Yes, I give permission to email me specials/info
- No, I do not give permission to email me specials/info

Hand Specialists of Dallas

- Yes, I give permission to email me specials/info
- No, I do not give permission to email me specials/info

Email: _____

Note: appointment reminders may be emailed as a normal course of business.

Patient's Signature **Date**

Witness **Date**

OR Guardian Signature | Relationship | Date



Consent for Photography

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I, as the patient identified above or the legal representative of such patient (“Patient”), consent to have photographs, videotapes, digital or audio recordings, and/or images of the Patient, and any other method to reproduce or edit such Patient’s likeness or image now known or hereafter developed (collectively, “Photography”), taken by any of the HIPAA Affiliated Covered Entities (“ACE”) owned by Thornwell H. Parker, III, including Thornwell H. Parker, III, MD, PA (d/b/a Skin Cancer Consultants), Elevate Medical Spa and Cosmetic Surgery, Dallas Hand Specialists of Dallas, and the Dallas Surgi Center, Inc. (collectively “The Practice”) and its staff. I understand that such Photography will be recorded to document and assist with the Patient’s care and to assist with The Practice health care operations.

I understand the Photography will become part of the Patient’s medical record and therefore protected, used and/or disclosed in accordance with The Practice’s Notice of Privacy Practices. I understand that The Practice will own the Photography and I will not receive any payment for such Photography, but that I will be allowed to access or view them or to obtain copies of them as part of the Patient’s medical record.

I have read this consent in its entirety and agree to be bound by all of its terms and conditions as described above. I acknowledge and agree that I have been given the opportunity to ask any questions and had all my questions answered to my satisfaction.

Patient Signature (or Legal Representative)

Date

Printed Name

Legal Representative’s Authority (if applicable)

Witness Signature (The Practice)

Date



****Optional** Release to Disclose Photographs for Patient Education**

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I, as the patient identified above or the legal representative of such patient (“**Patient**”), have consented to the taking of photographs, videotapes, digital or audio recordings, and/or images of Patient, and any other method to reproduce or edit such Patient’s likeness or image now known or hereafter developed (collectively, “**Photography**”), by any of the HIPAA Affiliated Covered Entities (“**ACE**”) owned by Thornwell H. Parker, including Thornwell H. Parker, III, MD, PA (d/b/a Skin Cancer Consultants), Elevate Medical Spa and Cosmetic Surgery, Dallas Hand Specialists, and the Dallas Surgi Center, Inc. (collectively “**The Practice**”) and its staff which will be part of my medical record. I also understand that the Photography that identify Patient can be released and/or used outside The Practice only upon written authorization from me.

The Practice desires to utilize the Photography for purposes of professional publications, training, education or clinical evaluation. The Practice IS NOT receiving direct or indirect remuneration from a third party in connection with the use/disclosure of the protected health information described in this authorization.

I authorize The Practice to use Patient’s Photography for purposes of patient education. In addition, I understand that the Photography may incidentally disclose additional protected health information related to Patient’s treatment, condition, procedure, or other protected health information associated with the Photography, and I authorize such disclosure.

This authorization is valid until the earlier of the occurrence of the death of Patient; Patient reaching the age of majority; or permission is withdrawn.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to The Practice’s Privacy Officer. I understand that a revocation is not effective to the extent that The Practice has relied on the use or disclosure of the protected health information. I understand that, except as otherwise provided in this authorization, The Practice may use or disclose my protected health information in accordance with The Practice’s Notice of Privacy Practices. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) or other applicable laws or regulations. I release and hold harmless The Practice, its officers, staff and employees from any and all claims or causes of action that I may have of any nature whatsoever, which may in any manner result from the use of the Photography. I understand that The Practice will not condition my treatment, payment or eligibility for benefits on whether I provide authorization for the requested use.

Patient Signature (or Legal Representative)

Date

Printed Name, Legal Representative’s Authority (if applicable)

Witness Signature (The Practice)

Date



****Optional** Release to Disclose Photographs for Marketing**

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

I, as the patient identified above or the legal representative of such patient (“Patient”), have consented to the taking of photographs, videotapes, digital or audio recordings, and/or images of Patient, and any other method to reproduce or edit such Patient’s likeness or image now known or hereafter developed (collectively, “Photography”), by any of the HIPAA Affiliated Covered Entities (“ACE”) owned by Thornwell H. Parker, including Thornwell H. Parker, III, MD, PA (d/b/a Skin Cancer Consultants), Elevate Medical Spa and Cosmetic Surgery, Dallas Hand Specialists, and the Dallas Surgi Center, Inc. (collectively “The Practice”) and its staff which will be part of my medical record. I also understand that the Photography that identify Patient can be released and/or used outside The Practice only upon written authorization from me.

The Practice desires to utilize the Photography for purposes of print and email marketing both of which will result in the publication and distribution of protected health information to the general public. The Practice IS NOT receiving direct or indirect remuneration from a third party in connection with the use/disclosure of the protected health information described in this authorization.

I authorize The Practice to use Patient’s Photography in its print and digital marketing. I understand that the Photography may incidentally disclose additional protected health information related to Patient’s treatment, condition, procedure, surgery or other protected health information associated with the Photography, and I authorize such disclosure.

This authorization is valid until the earlier of the occurrence of the death of Patient; Patient reaching the age of majority; or permission is withdrawn.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to The Practice’s Privacy Officer. I understand that a revocation is not effective to the extent that The Practice has relied on the use or disclosure of the protected health information. I understand that, except as otherwise provided in this authorization, The Practice may use or disclose my protected health information in accordance with The Practice’s Notice of Privacy Practices. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) or other applicable laws or regulations. I release and hold harmless The Practice, its officers, staff and employees from any and all claims or causes of action that I may have of any nature whatsoever, which may in any manner result from the use of the Photography. I understand that The Practice will not condition my treatment, payment or eligibility for benefits on whether I provide authorization for the requested use.

Patient Signature (or Legal Representative)

Date

Printed Name, Legal Representative’s Authority (if applicable)

Witness Signature (The Practice)

Date



Notice of Privacy Practices Acknowledgement

I understand that, under the **Health Insurance Portability & Accountability Act of 1996** (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have been provided the *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I acknowledge that my medical information/records will be released to The Practice. I further acknowledge that my medical information/records will be released from The Practice to my primary care provider, referring/consulting providers, and to my insurance company to process insurance claims.

I also allow release of my medical information to the following individuals: (i.e. family, caregivers, etc.)

Name:	Relationship:
_____	_____
_____	_____

Patient Name _____

_____	_____	_____	_____
Patient's Signature	Date	Witness	Date

_____	_____	_____
OR Guardian Signature	Relationship	Date



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Understanding Your Health Record Information

The notice describes the practices of the HIPAA Affiliated Covered Entities: Thornwell H. Parker, III, MD, PA (d/b/a Skin Cancer Consultants), Elevate Medical Spa and Cosmetic Surgery, Dallas Hand Specialists of Dallas, and the Dallas Surgi Center, Inc. (collectively "The Practice") and that of any physician or provider with staff privileges with respect to your protected health information created while you are a patient at The Practice. The Practice, physicians with staff privileges, and personnel authorized to have access to your medical chart are subject to this notice. In addition, The Practice and physicians with staff privileges may share medical information with each other for treatment, payment or health care operations described in this notice

We create a record of the care and services you receive at The Practice. We understand that medical information about you and your health is personal. We are committed to protecting medical information about you. This notice applies to all of the records of your care at The Practice.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information

Your Health Information Rights

Although your health record is the physical property of The Practice, the information belongs to you. You have the following rights to:

- Request a restriction on certain uses and disclosures of your information for treatment, payment, health care operations and as to disclosures permitted to persons, including family members involved with your care and as provided by law. However, we are not required by law to agree to a requested restriction, unless the request relates to a restriction on disclosures to your health insurer regarding health care items or services for which you have paid out-of-pocket and in-full.
- Obtain a paper copy of this notice of information practices.
- Inspect and request a copy of your health record as provided by law.
- Request that we amend your health record as provided by law. We will notify you if we are unable to grant your request to amend your health record.
- Obtain an accounting of disclosures of your health information as provided by law.
- Request communication of your health information by alternative means or at alternative locations. We will accommodate reasonable requests.

You may exercise your rights set forth in this notice by providing a written request to 8230 Walnut Hill Ln., STE 808, Dallas, TX 75231



Our Responsibilities

In addition to the responsibilities set forth above, The Practice is also required to

- Maintain the privacy of your health information
- Subject to certain exceptions under the law, provide notice of any unauthorized acquisition, access, use or disclosure of your protected health information to the extent it was not otherwise secured.
- Provide you with a notice as to our legal duties and privacy practices with respect to information we maintain about you
- Abide by the terms of this notice.
- Notify you if we are unable to agree to a requested restriction on certain uses and disclosures.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain, including information created or received before the change. Should our information practices change we are not required to notify you, but we will have the revised notice available upon your request at The Practice.

Uses and Disclosures of Medical Information That Do Not Require Authorization

The following categories describe different ways that we may use and disclose medical information without your authorization. For each category of uses or disclosures we will explain what we mean, but not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information without your authorization should fall within one of the categories

We will use your health information for treatment

For example: We may disclose medical information about you to doctors, nurses, technicians, medical students, or other personnel who are involved in taking care of you. We may share medical information about you in order to coordinate different treatments, such as prescriptions, lab work and x-rays. We may also provide your physician or a subsequent health-care provider with copies of various reports to assist in treating you once you are discharged from care at The Practice.

We will use your health information for payment

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used

We will use your health information for regular health care operations

For example: We may use the information in your health record to assess the care and outcome in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and services we provide.

We will use and disclose your health information as otherwise allowed by law. Examples of those uses and disclosures follow:



Business associates: There are some services provided in our organization through agreements with business associates. Examples include answering services and copy services. To protect your health information, however, we require business associates to appropriately safeguard your information.

Notification: Unless you object, we may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care about your location and general condition.

Individuals involved in your care: Unless you object, we may disclose to a family member, other relative, a close personal friend or other person you identify the health information that is directly relevant to that person's involvement in your health care or payment for your health care. If you are not able to agree or object to such disclosure, we may disclose the information as necessary if we determine it is in your best interest in our professional judgment.

Disaster relief: We may use or disclose your health information to public or private disaster relief organizations to coordinate your care or to notify your family or friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to these disclosures when practical.

Research/Teaching/Training: We may use medical information for research purposes provided we receive certain documentation or representations. We may also use and disclose your health information and photos for teaching and training medical professionals.

Communications regarding treatment alternatives and appointment reminders: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, medications, devices, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Worker's compensation: We may disclose your health information to the extent authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Abuse, neglect or domestic violence: As required by law, we may disclose health information to a governmental authority authorized by law to receive reports of abuse, neglect, or domestic violence.

Judicial, administrative and law enforcement purposes: Consistent with applicable law, we may disclose health information about you for judicial, administrative and law enforcement purposes.

Health oversight activities: We may disclose health information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections and licensure



Threats to health or safety: We may use or disclose health information as allowed by law if we believe in good faith that it is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public or for law enforcement authorities to identify or apprehend an individual involved in a crime.

Special government functions: We may disclose health information to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law, or for protective services to the President of the United States or certain other government officials. If you are a member of the military, we may disclose health information to military authorities under some circumstances. If you are an inmate of a jail, prison or other correctional facility or in the custody of law enforcement personnel, we may disclose health information necessary for your health and the health and safety of others.

Required or allowed by law: We will disclose medical information about you when required or allowed to do so by federal, state or local law.

Electronic Health Information Exchange: The Practice uses a third party to maintain our electronic medical records (EMR). The Practice stores electronic health information about you in the EMR. The Practice monitors who can view your health information.

When We Need Your Written Authorization

We will not use or disclose your health information without your written authorization, except as described in this notice. Additional uses that might require your additional written authorization are not common, but an example would be uses and disclosures for marketing purposes.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact The Practice at 214-696-8828.

If you believe your privacy rights have been violated, you can send a complaint to the Director of The Practice at: Thornwell H. Parker, III, MD, 8230 Walnut Hill Ln., STE 808, Dallas, TX 75231 or with the Department of State Health Services, Manager, Health Facility Compliance Group, Post Office Box 149347, Austin, Texas 78714-9347, (888) 973.0022. There will be no retaliation for filing a complaint

