

**THE UNIVERSITY OF TEXAS HEALTH CENTER AT TYLER (UTHCT)  
ADMISSION AND OUTPATIENT CONSENT FORM**

The following statements apply to all health care providers within UTHCT, unless otherwise specified.

**CONSENT TO TREATMENT**

I hereby consent to and authorize UTHCT to perform such tests and examinations that are prescribed by my physician(s), the professional health care providers of UTHCT, or by their assistants, associates or consultants.

I understand UTHCT may release or furnish copies of medical and/or billing record information as permitted by state and federal law. I understand that my medical record may include history of or treatment of **drug or alcohol abuse**, history of treatment of **mental health conditions**, or history of or treatment of **Acquired Immune Deficiency Syndrome (AIDS)**, or related condition.

I hold harmless UTHCT, its employees and agents, including all physicians, from any civil liability, and waive on behalf of myself and any persons who may have an interest in my medical care, person, or estate, all provisions of law relating to the disclosure of information reflected in my medical record as required or permitted by state and federal law.

I understand that this is a university hospital with a mission of patient care, education and research. Information contained in my medical record may be reviewed by the Health Center faculty and staff in connection with research projects and teaching activities conducted by this institution. Such reviews are confidential. If information obtained in a record review is used in a project, my name will not be revealed.

I understand that a University hospital has a mission to educate; and, at times there are healthcare professionals in training in attendance at the hospital who may be observing or participating in procedures and treatments involving patients. These trainees are supervised and are required to respect patient privacy.

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**TO BE COMPLETED BY ADMITTING FOR INPATIENTS ONLY**

**The patient:**

- Has an advance directive (directive is attached).**
- Has an advance directive filed in the patient's UTHCT medical record.**
- Has an advance directive, but the directive is not here at the Health Center. I requested that patient or patient's representative arrange for form to be brought to UTHCT.**
- Does not have an advance directive. I have provided the patient (or the patient's representative) with an information packet on Advance Directives.**

Patient Registration Representative: \_\_\_\_\_ Date: \_\_\_\_\_

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I have read and understand the above statements and understand that my signature pertains to each of them.

\_\_\_\_\_  
Referring Physician's Name

\_\_\_\_\_  
Family or Primary Care Physician Name

\_\_\_\_\_  
Address  
Phone Number: \_\_\_\_\_

\_\_\_\_\_  
Address  
Phone Number: \_\_\_\_\_

\_\_\_\_\_  
Printed name of patient

\_\_\_\_\_  
Signature of PATIENT or LEGAL REPRESENTATIVE  
Approved by MIMC 02/01, Rev. 11/02, Rev. 12/02

\_\_\_\_\_  
Date