

BARRY LIBERONI, M.D., P.A.
INTERNAL MEDICINE

COMPLETE ALL SECTIONS
PERSONAL INFORMATION
2026

Patient (LEGAL) Name:		Date of Birth:		Social Security #:	
Mailing Address		City, State, Zip:		Home # ()	Cell Phone # ()
Email Address:		Employer Name:		Employer phone:	
Sex: M F		Marital Status: M S D W		Valid Texas Drivers Licenses Number:	
Name of Spouse or Guarantor:		Spouse or Guarantor S.S #:		Spouse or Guarantor Cell Phone #	
In Case of Emergency Nearest Relative Not Living with You:					Phone # ()
FULLY COMPLETE THIS SECTION					
O.K. to leave message with detailed information at home Yes <input type="checkbox"/> or No <input type="checkbox"/>			O.K. to leave message with call-back number Home only <input type="checkbox"/> Work only <input type="checkbox"/> Both <input type="checkbox"/>		
O.K. to contact via e-mail Yes <input type="checkbox"/> or No <input type="checkbox"/>			E-Mail Address (Strictly Confidential)		
PAYMENT FOR SERVICES RENDERED IS DUE AT THE TIME SERVICES ARE RENDERED:					
INSURANCE AUTHORIZATION:					
<p>I understand and agree that, (regardless of my insurance status); I am ultimately responsible for the balance of my account for any professional services rendered. I have completed the New Patient Information form and I certify that this information is true and correct to the best of my knowledge. I will notify you of any change in the above information.</p> <p>I authorize disclosure of my health information to the insurers on record, or to any agency concerned with the payment of my health care charges, any and all information related to acquired immunodeficiency syndrome (AIDS), infection with human immunodeficiency virus (HIV), psychiatric care, or treatment for alcohol or drug abuse relating to this episode of care.</p>					
Signature of Patient or Responsible Party:			Date:		

OFFICE USE ONLY	
Date Insurance Verified:	Referrals Needed Yes <input type="checkbox"/> or No <input type="checkbox"/>

Full Name: _____

Date of Birth: _____

Family History	YES	NO	Current Age (S)	Age at Death
Is Your Mother Living?	<input type="checkbox"/>	<input type="checkbox"/>		
Is Your Maternal Grandmother Living?	<input type="checkbox"/>	<input type="checkbox"/>		
Is Your Maternal Grandfather Living?	<input type="checkbox"/>	<input type="checkbox"/>		
Is Your Father Living?	<input type="checkbox"/>	<input type="checkbox"/>		
Is Your Paternal Grandmother Living?	<input type="checkbox"/>	<input type="checkbox"/>		
Is Your Paternal Grandfather Living?	<input type="checkbox"/>	<input type="checkbox"/>		
Do You Have Any Brothers Living?	<input type="checkbox"/>	<input type="checkbox"/>		
Do You Have Any Sisters Living?	<input type="checkbox"/>	<input type="checkbox"/>		

Social History					
Place of Birth? _____			Marital Status: M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/>		
How Many Natural Children do you have?			Age of Children?		
Have You Ever Attended College?	YES	NO	Previous Military Service?	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
List Your Hobbies: _____ _____					

Male History

Name: _____

D.O.B.: _____

Personal Medical History

Please List Previous Doctors You Have Seen in the Last 10 Years:
(Include Surgeons, Specialists, and Your Primary Care Physicians)

Name	City/State

Please List Allergies to Medications, Latex, Food (Shellfish)	

Please List Current Medications and Dietary Supplements: Name/Dosage	

Please Answer The Following Questions About Your Tobacco and / or Alcohol Use:					
Do You Currently Use Tobacco?	YES	NO	Do You Currently Use Alcohol?	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
If So, How Many Years? _____			How Much Per Day Average? _____		
How Much Per Day? _____			Have You Used Alcohol In The Past?	YES	NO
				<input type="checkbox"/>	<input type="checkbox"/>
Have You Used Tobacco in the past?	YES	NO	Are you currently or within the last 2 years taking a prescribed controlled substance or any habit forming drug?	YES	NO
	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
If Yes, How Many Years Since You Quit? _____			Are you currently or within the last 2 years taking any illegal street drugs?	YES	NO
				<input type="checkbox"/>	<input type="checkbox"/>

What Is Your Enlarged Prostate (EP) System Score						
Use This Scorecard of Symptoms. Circle One Number in Each Line. Add 7 Circled Numbers to get a Total Score.						
Over The Past Month, How Often Have You.....	Not At All	Less Than 1 In 5	Less Than Half	About Half	More Than Half	Almost Always
Had a Sensation Of Not Emptying Your Bladder Completely After You Finished Urinating?	0	1	2	3	4	5
Had To Urinate Again Less Than 2 hours After You Finished	0	1	2	3	4	5
Stopped And Started Again Several Times When You Urinated?	0	1	2	3	4	5
Found It Difficult To Postpone Urination?	0	1	2	3	4	5
Had a Weak Urinary Stream?	0	1	2	3	4	5
Had To Push or Strain to Begin Urination?	0	1	2	3	4	5
	None	1 Time	2 Times	3 Times	4 Times	5 Or More
Over The Past Month, How many Times Did You Typically Get Up To Urinate From The Time You Went To Bed At Night Until The Time You Got Up In The Morning	0	1	2	3	4	5
(YOUR SCORE) Symptom Score: <input type="text"/> 1-7 Mild <input type="text"/> 8-19 Moderate <input type="text"/> 20-35 Severe						

Past Medical History and Family Medical History

Fill in the circle in the column labeled "Self" to indicate if you have any of these diseases. If any of these diseases run in your family, please indicate which relative(s) have the problem by filling in the circle(s). Use the numbers to the left of the circles and the letters in the circles to help keep your place. This information is very important to us and will help us take better care of you.

Allergy/Immunology

- 1. Seasonal Allergies
- 2. Asthma

Cardiovascular

- 1. Hypertension (high blood pressure)
- 2. Cardiac arrest (heart attack)
- 3. Congestive heart failure
- 4. Pacemaker
- 5. Rapid or Irregular Heart Beats
- 6. Peripheral Vascular Disease
- 7. Rheumatic Heart Disease
- 8. Cerebrovascular accident (stroke)
- 9. Transient ischemia attacks ("little strokes")

	Self		Mother	Father	Brother	Sister	Grandmother	Grandfather
1.	()	1.	(A)	(B)	(C)	(D)	(E)	(F)
	()							
2.	()	2.	(A)	(B)	(C)	(D)	(E)	(F)
	()							
1.	()	1.	(A)	(B)	(C)	(D)	(E)	(F)
	()							
2.	()	2.	(A)	(B)	(C)	(D)	(E)	(F)
	()							
3.	()	3.	(A)	(B)	(C)	(D)	(E)	(F)
	()							
4.	()	4.	(A)	(B)	(C)	(D)	(E)	(F)
	()							
5.	()	5.	(A)	(B)	(C)	(D)	(E)	(F)
	()							
6.	()	6.	(A)	(B)	(C)	(D)	(E)	(F)
	()							
7.	()	7.	(A)	(B)	(C)	(D)	(E)	(F)
	()							
8.	()	8.	(A)	(B)	(C)	(D)	(E)	(F)
	()							
9.	()	9.	(A)	(B)	(C)	(D)	(E)	(F)

Gastrointestinal

1. Stomach Ulcers
2. Gastro esophageal Reflux (*Heart Burn)
3. Hiatal Hernia
4. Irritable Bowel Syndrome
5. Inflammatory Bowel Disease (Crohn's or Ulcerative Colitis)
6. Polyps in colon
7. Diverticulitis
8. Gallstones
9. Pancreatitis
10. Hepatitis
11. Appendicitis
12. Colon cancer
13. Cirrhosis of the liver

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	Mother	Father	Brother	Sister	Grandmother	Grandfather
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2.	(A)	(B)	(C)	(D)	(E)	(F)
3.	(A)	(B)	(C)	(D)	(E)	(F)
4.	(A)	(B)	(C)	(D)	(E)	(F)
5.	(A)	(B)	(C)	(D)	(E)	(F)
6.	(A)	(B)	(C)	(D)	(E)	(F)
7.	(A)	(B)	(C)	(D)	(E)	(F)
8.	(A)	(B)	(C)	(D)	(E)	(F)
9.	(A)	(B)	(C)	(D)	(E)	(F)
10.	(A)	(B)	(C)	(D)	(E)	(F)
11.	(A)	(B)	(C)	(D)	(E)	(F)
12.	(A)	(B)	(C)	(D)	(E)	(F)
13.	(A)	(B)	(C)	(D)	(E)	(F)

Endocrine

1. Diabetes ("High Blood Sugar")
2. Hypoglycemia ("Low Blood Sugar")
3. Hyperthyroidism ("high" or "overactive" thyroid)
4. Obesity
5. Hypothyroidism ("low thyroid")

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	Mother	Father	Brother	Sister	Grandmother	Grandfather
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3.	(A)	(B)	(C)	(D)	(E)	(F)
4.	(A)	(B)	(C)	(D)	(E)	(F)
5.	(A)	(B)	(C)	(D)	(E)	(F)

Pulmonary / Respiratory / Lungs

1. Asthma
2. COPD ("emphysema")
3. Chronic bronchitis ("smoker's cough")
4. Tuberculosis
5. Lung cancer
6. Sleep apnea

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	Mother	Father	Brother	Sister	Grandmother	Grandfather
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3.	(A)	(B)	(C)	(D)	(E)	(F)
4.	(A)	(B)	(C)	(D)	(E)	(F)
5.	(A)	(B)	(C)	(D)	(E)	(F)
6.	(A)	(B)	(C)	(D)	(E)	(F)

Hematology / Blood Diseases:

1. Anemia
2. Sickle cell anemia
3. Leukemia
4. Easy bleeding
5. History of blood clots

Oncology / Cancers (unless otherwise covered)

1. Breast cancer
2. Fibroids
3. Prostate cancer
4. Brain cancer
5. Bone cancer

Neurological (Disorders of the Nervous System)

1. Migraines
2. Headaches
3. Seizures / Convulsions
4. Tremors
5. Alzheimer's Disease
6. Menière's Disease
7. Huntington's Chorea
8. Cerebrovascular accidents (stroke)
9. Transient Ischemic Attacks ("little strokes")
10. Parkinson's Disease
11. Meningitis
12. Concussion
13. Bell's palsy

Psychiatric Disorders

1. Depression
2. Schizophrenia

[illegible]

3. Anxiety disorder
4. Alcoholism
5. Drug dependence
6. Bipolar disorder

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3. (A) (B) (C) (D) (E) (F)
4. (A) (B) (C) (D) (E) (F)
5. (A) (B) (C) (D) (E) (F)
6. (A) (B) (C) (D) (E) (F)

Kidney Disease

1. Renal Failure (Dialysis)
2. Polycystic Kidney Disease
3. Kidney stones
4. Chronic bladder infections
5. Kidney cancer
6. Bladder cancer

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- | Mother | Father | Brother | Sister | Grandmother | Grandfather |
|----------------------------|--------|---------|--------|-------------|-------------|
| 1. (A) (B) (C) (D) (E) (F) | | | | | |
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| 3. (A) (B) (C) (D) (E) (F) | | | | | |
| 4. (A) (B) (C) (D) (E) (F) | | | | | |
| 5. (A) (B) (C) (D) (E) (F) | | | | | |
| 6. (A) (B) (C) (D) (E) (F) | | | | | |

Rheumatology (Musculoskeletal/Connective Tissue)

1. Osteoarthritis (Degenerative Joint Disease)
2. Gout
3. Scleroderma
4. Vasculitis
5. Rheumatoid Arthritis
6. Systemic Lupus Erythematosus
7. Osteoporosis
8. Juvenile Arthritis

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- | Mother | Father | Brother | Sister | Grandmother | Grandfather |
|----------------------------|--------|---------|--------|-------------|-------------|
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| 2. (A) (B) (C) (D) (E) (F) | | | | | |
| 3. (A) (B) (C) (D) (E) (F) | | | | | |
| 4. (A) (B) (C) (D) (E) (F) | | | | | |
| 5. (A) (B) (C) (D) (E) (F) | | | | | |
| 6. (A) (B) (C) (D) (E) (F) | | | | | |
| 7. (A) (B) (C) (D) (E) (F) | | | | | |
| 8. (A) (B) (C) (D) (E) (F) | | | | | |

PERSONAL SURGICAL HISTORY

(Gallbladder, Tonsils, Hysterectomy, C-Section, Breast, Hernia, Prostate, Bladder, Shoulder, Hip, Knee, foot, Neck, Back)

Type Of Surgery	When	Surgeon

Other Important Medical Diagnosis

Sleep History Questionnaire

I Have The Following Concerns About My Sleep Habits: (Check Where Applicable)

I Snore In My Sleep		Bedtime Varies A Lot	
I Have Been Told That I Stop Breathing In My Sleep		Teeth Grinding In Sleep	
Restless/Disturb Sleep		Irregular/Rapidly Pounding Heart	
Difficulty Maintaining Sleep		Poor Quality Sleep	
Nasal Blockage During Sleep		Excessive Daytime Sleepiness	
At Bedtime, I Worry About Things		Falling Asleep At Inappropriate Times	
Difficulty Initiating Sleep		Wakeup With Dry Mouth	
My Snoring Bothers Others		Sweat In My Sleep	
Wake Up Gasping		Getting Too Little Sleep	

What time do you go to bed each night? _____

How long does it take for you to go to sleep? _____

How many times do you wake up at night? _____

What Wakes You Up? ☐ Snoring ☐ External Noises ☐ Choking Sensation ☐ Urge To Urinate ☐ Unknown Reason

How Many Naps Do You Take Per Day? _____ For How Long? _____

What Time Do You Get Up On Weekdays? _____ On Weekends? _____

How many caffeinated drinks per day? _____

Do You Work Different Shifts? _____ If So, For How Many Years? _____

D.O.B.: _____

Review of Systems

Page 1 of 2

General				Eyes			
No problems		N	Y	No problems		N	Y
Gain or loss of 10 pounds in past year				Decreased vision			
Fever				Near sightedness			
Chills				Far sightedness			
Anorexia				Dry eyes			
Tiredness without effort				Itchy eyes			
Increased thirst or appetite				Watery eyes			
				Thick discharge from eyes			
				Frequent Conjunctivitis			
				Pain in eyes			
				Sensitive to light			
				Double vision			
				Spots in vision			
				Halos around lights			
Endocrine							
No problems							
Tendency to feel too hot							
Tendency to feel too cold							
Frequent need to urinate							
Markedly increased thirst							
Hands shaking or trembling							
Skin				Ears			
No problems				No problems			
Itching				Decreased hearing			
Rash				Ringing in ear(s)			
Change in mole				Drainage from ear(s)			
Persistent skin problem				Pain in ear(s)			
Mouth				Cardiovascular			
No problems				No problems			
Dry mouth				Shortness of breath			
Excessive saliva				Awakening at night breathless			
Bleeding gums				Unable to sleep lying flat			
Ulcers in mouth				Lightheadedness/Dizziness			
Pain in mouth				Rapid heart beat (Palpitations)			
Change in tastes				Decreased exercise tolerance			
Respiratory							
No problems							
Breathing problems				Chest pain			
Coughing spells				Chest pressure			
Wheezing				Chest discomfort			
Coughing up blood				Painful fingers/toes when in cold room			
Painful cough				Fainting spells			
Frequent chest congestion				Pain/Cramps in legs while at rest			
Coughing up phlegm (mucous, cold)				Pain/Cramps in legs while walking			
				Swollen feet and ankles			
Musculoskeletal							
No problems							
Pain in neck							
Pain in high back							
Pain in low back							
Pain in mid back							
Pain in sacrum							
Joint pain							
Joint swelling							
Joint stiffness							
Muscle pain							
Morning stiffness							
Weakness in muscles							
Frequent muscle spasms							
Frequent cramps							

Name: _____
D.O.B: _____

Review of Systems

Page 2 of 2

Allergy/Immunologic		N	Y	Psychiatric		N	Y
No problems <input type="checkbox"/> Spontaneous wheals on skin (Urticaria) <input type="checkbox"/> Runny nose <input type="checkbox"/> Sinus congestion <input type="checkbox"/> Sneezing <input type="checkbox"/> Seasonal runny nose, eyes or sore throat <input type="checkbox"/> Asthma <input type="checkbox"/> Allergies <input type="checkbox"/> Many infections <input type="checkbox"/> Prolonged time to heal <input type="checkbox"/> Prolonged time to fight off infections <input type="checkbox"/> Frequent illnesses ("sickly", "poorly") <input type="checkbox"/>				No problems <input type="checkbox"/> Problems with depression <input type="checkbox"/> Problems with anxiety <input type="checkbox"/> Phobias (extreme fears) <input type="checkbox"/> Seeing things <input type="checkbox"/> Hearing things <input type="checkbox"/> Memory problems <input type="checkbox"/> Alcohol abuse <input type="checkbox"/> Substance abuse <input type="checkbox"/> Insomnia (problems sleeping) <input type="checkbox"/> Changes in sleep pattern <input type="checkbox"/> Changes in behavior <input type="checkbox"/>			
Nose No problems <input type="checkbox"/> Abnormal odors <input type="checkbox"/> Nose bleeding <input type="checkbox"/> Nasal drainage <input type="checkbox"/> Pain in nose <input type="checkbox"/> Congestion <input type="checkbox"/>				Hematologic/Lymphatic No problems <input type="checkbox"/> Swollen lymph nodes or lumps in neck <input type="checkbox"/> Swollen lymph nodes or lumps in armpits <input type="checkbox"/> Swollen lymph nodes or lumps in groin <input type="checkbox"/> Dusky color (pale lips, gums, skin) <input type="checkbox"/> Itching everywhere <input type="checkbox"/> Easy bruising <input type="checkbox"/> Prolonged bleeding <input type="checkbox"/> Extreme fatigue <input type="checkbox"/>			
Throat No problems <input type="checkbox"/> Hoarse voice without a cold <input type="checkbox"/> Sore throat with fever <input type="checkbox"/> Problems swallowing <input type="checkbox"/> Lumps or swelling in throat <input type="checkbox"/>				Gastrointestinal No problems <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Heartburn <input type="checkbox"/> Indigestion <input type="checkbox"/> Reflux <input type="checkbox"/> Frequent belching <input type="checkbox"/> Bloating <input type="checkbox"/> Flatulence (Gas) <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting of blood <input type="checkbox"/> Constipation <input type="checkbox"/> Frequent loose or watery stools <input type="checkbox"/> Recent change in bowel habits <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Tarry black stools <input type="checkbox"/> Maroon colored stools <input type="checkbox"/> Blood on stool <input type="checkbox"/> Pain in rectum <input type="checkbox"/> Abdominal pain <input type="checkbox"/>			
Neurological No problems <input type="checkbox"/> Frequent headaches <input type="checkbox"/> Convulsions <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Paralysis <input type="checkbox"/> Strokes <input type="checkbox"/> Muscles wasting away <input type="checkbox"/> Involuntary movements <input type="checkbox"/> Problems with walking <input type="checkbox"/> Problems with coordination <input type="checkbox"/> Hands shaking or trembling <input type="checkbox"/> Numbness or tingling in hands or feet <input type="checkbox"/> Problems with memory <input type="checkbox"/> Dizziness <input type="checkbox"/>							
Genitourinary No problems <input type="checkbox"/> Painful urination <input type="checkbox"/> Bloody urine <input type="checkbox"/> Incontinence (uncontrolled urination) <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Urinary frequency <input type="checkbox"/>				For Women Only No problems <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Vaginal itching <input type="checkbox"/> Abnormal menstrual periods <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Repeated pain during intercourse <input type="checkbox"/> Bleeding after intercourse <input type="checkbox"/> Post-menopausal bleeding <input type="checkbox"/> Hot flashes <input type="checkbox"/> Are you pregnant, or think you might be? <input type="checkbox"/> Lumps in breasts <input type="checkbox"/> Discharge or bleeding from either nipple <input type="checkbox"/> Are you using birth control? <input type="checkbox"/>			
For Men Only No problems <input type="checkbox"/> Scrotal swelling <input type="checkbox"/> Mass or lump in scrotum <input type="checkbox"/> Penile discharge <input type="checkbox"/> Decreased urinary stream <input type="checkbox"/> Impotence <input type="checkbox"/> Excessive testicular tenderness <input type="checkbox"/> Lesions on genitals <input type="checkbox"/> Swelling in groin <input type="checkbox"/>							

BARRY LIBERONI, M.D., P.A.
720 Avenue F. North. Suite. 3
Bay City, Texas 77414
Phone - (979) 245-9797
Fax – (979) 245-9789

NOTICE TO ALL PATIENTS

EFFECTIVE 02/01/2026

We would like to inform you of additional charges that may be incurred from this office that are separate from the standard fees for an office visit.

- 1. Cancelled Office Visit With Less Than 24 Hours Notice
OR IF NO SHOW FOR AN APPOINTMENT
(Please Note If You are In The Emergency Room or an Inpatient at a
Hospital we will waive the fee)**

Per Occurance \$75.00 Fee
- 2. Forms that need to be filled out \$75.00 (Minimum Fee)**
FMLA or Other Work-Related Forms
Personal Disability (Non-Federal)
Leave of Absence Forms or Letters
PLEASE NOTE: There is No Charge with an office visit
- 3. A request for any Letter that has to be drawn up and typed by this office...**
(such as an exemption from jury duty, refund for a flight cancellation or
cruise, a tax savings letter for the purchase of a new mattress or hot tub)
There will be a \$75.00 MINIMUM CHARGE for the Letter

THE ABOVE FEES ARE NOT COVERED BY YOUR INSURANCE COMPANY

I Acknowledge Receipt of this Notice

Patient's Signature

Patient's Name (Please Print)

Today's Date

Barry J. Liberoni, M.D., P.A.

**Medical Information Release Form
(HIPAA Release Form)**

Name: _____ Date of Birth: ____/____/____

Release of Information

☐ I authorize the release of information including the diagnosis, records;
examination rendered to me and claims information.

This information may be released to:

☐ Spouse _____

☐ Child (ren) _____

☐ Other _____

☐ Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call ☐ my home ☐ my work ☐ my Cell Number: _____

If unable to reach me:

☐ you may leave a detailed message

☐ please leave a message asking me to return your call

☐ _____

The best time to reach me is (day) _____ between (time) _____

Signed: _____ Date: ____/____/____

Witness: _____ Date: ____/____/____

BARRY J. LIBERONI, M.D.,P.A

AUTHORIZATION FOR: ☐ Disclosure ☐ Inspection ☐ Amendment

Of Protected Health Information

Patient Name	D.O.B	SS #
Address		Telephone #

Previous Physicians Information

Previous Physician (s) Name Phone Number Address

I hereby authorize:

To release the information from the medical records of:

Patients Name

RELEASE MEDICAL RECORDS TO

Barry J. Liberoni, M.D.,P.A.

720 Ave F North, Ste. 3

Bay City, Texas 77414

Phone# (979) 245-9797 / Fax # (979) 245-9789

For The Treatment Dates: **ALL TREATMENT DATES**

For The Following Purpose: ☐ Continued Medical Care ☐ Legal ☐ Insurance ☐ Other _____

Select One Of The Following

- ☐ Abstract/Pertinent Information
- ☐ Lab
- ☐ Emergency
- ☐ Imaging/Radiology
- ☐ H & P
- ☐ Cardiac Studies
- ☐ MD Progress Notes

- ☐ MD Orders
- ☐ Operative/Procedure Report
- ☐ Entire Record EXCLUDING - HIV Testing & Chemical Dependency
- ☐ Entire Record INCLUDING - HIV Testing & Chemical Dependency
- ☐ Entire Record INCLUDING - HIV Testing Only
- ☐ Entire Record INCLUDING - Chemical Dependency Only
- ☐ Other _____

This authorization is valid until the 180th day after the date it is signed unless it provides otherwise, not to exceed 24 months, or unless it is revoked, and covers only treatment (s) for the date specified above.

I, the undersigned, have read the above and authorized the staff of _____ to disclose such information as herein contained. I have the right to revoke this authorization in writing at any time except to the extent that action have been taken in reliance upon it. I understand that when this information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and my no longer be protected. I hereby release and hold harmless the above mentioned name facility and its parent company from any and all liability and damages resulting from the lawful release of my Protected Health Information.

Date

Signature of Patient/Parent/Conservator/Guardian

Authority/Relationship to

PATIENT RECORD OF DISCLOSURES

In general, the HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone:

- ☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only

☐ Written Communication Via Email:

- ☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only

☐ Cellphone:

- ☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only

☐ Work Telephone:

- ☐ O.K. to leave message with detailed information
☐ Leave message with call-back number only

Patient Signature

Date

Print Name

Birthdate

The Privacy Rule generally requires healthcare providers to make reasonable steps to limit the use or disclosure of and requests for PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses of disclosures made pursuant to an authorization requested by the individual.

Healthcare entities must keep records of PHI disclosure. Information provided below, if completed properly, will constitute an adequate record.

Note: Uses and disclosures to TPO may be permitted without prior consent in an emergency.

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Address or Fax Number	(1)	Description of Disclosure/ Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized

(2) Type Code: T= Treatment Records; P=Payment Information; O=Healthcare Operations

(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

PATIENT RECORD OF DISCLOSURES

Record of Disclosures of Protected Health Information Continued

[illegible]

(1) Check this box if the disclosure is authorized

(2) Type Code: T= Treatment Records; P=Payment Information; O=Healthcare Operations

(3) Enter how disclosure was made: F=Fax; P=Phone; E=Email; M=Mail; O=Other

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.

This notice took effect on April 14, 2003 and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We create a record of the care and services you receive at our organization. We need this record to provide you with quality care and to comply with certain legal requirements. This notice will tell you about the ways we may use and share medical information about you. We also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy practices, and your right regarding your medical information.
3. Follow the terms of the notice that is now in effect.

We Have the Right to:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.
2. Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.

Notice of Change to Privacy Practices:

1. Before we make an important change in our privacy practices, we will change this notice and make the new notice available upon request.

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose medical information. We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

Example: You are in the hospital with a broken leg. You also have diabetes.

A number of health care and support staff need to know about your diabetes during

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your stay:

- * The doctor treating you for the broken leg needs to know if you have diabetes because diabetes may slow the healing process.
- * The dietitian needs to know about your diabetes to arrange for proper meals.
- * The pharmacy needs to know about possible medicines that you may need as a diabetic.
- * The information about your diabetes may help in diagnostics, testing, and x-ray work.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

Example: You are treated in the hospital for a broken leg.

- * We may need to give your health insurance information about surgery you received at our organization so that your health plan will pay us or repay you for any surgery that you paid for.
- * We may also tell your health plan about a treatment you are going to receive to get approval or to determine if your plan will pay for the treatment.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment, and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: Unless you notify us that you object, the following medical information about you will be placed in our facilities' directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy or, except for your religious affiliation, to others who contact us and ask for information about you by name.

Notification: Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition or death. If you are present, we will get your permission if possible before we share, or give you opportunity to refuse permission. In case of emergency, and if you are not able to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgement. We will also use our professional judgment to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for you.

Disaster Relief: Medical information with a public or private organization or person who can legally assist in disaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care. In any fundraising materials, we will provide you a description of how you may choose not to receive future fundraising communications.

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Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.

Specialized Government Functions: Subject to certain requirements, we may disclose or use health information for military personnel and veterans, for national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and other law enforcement custodial situations, and for government programs providing public benefits.

Court Orders and Judicial and Administrative Proceedings: We may disclose medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an inmate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.

Public Health Activities: As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products, or to conduct activities required by the Food and Drug Administration. We may also, when we are authorized by law to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contracting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose medical information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health or safety or the health or safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being part of a crime or has escaped from legal custody.

Workers Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, or criminal investigations or proceedings, inspections, licensure or disciplinary actions, or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

NOTICE OF PRIVACY PRACTICES

4. YOUR INDIVIDUAL RIGHTS

You Have a Right to:

1. Look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter to the contact person listed at the end of this notice. If you request copies, we will charge you \$10.00 for research and retrieval, \$15.00 for the first 25 pages, and \$0.25 per page for each additional page, and postage if you want the copies mailed to you. If sent via facsimile we will charge you \$1.00 per faxed page. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
2. Receive a list of all the times we or our business associates shared your medical information for purposes other than treatment, payment, and health care operations and other specified exceptions.
3. Request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in the case of an emergency).
4. Request that we communicate with you about your medical information by different means or to different locations. Your request that we communicate your medical information to you by different means or at different locations must be made in writing to the contact person listed at the end of this notice.
5. Request that we change your medical information. We may deny your request if we did not create the information you want changed or for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement of disagreement that will be added to the information you wanted change. If we accept your request to change the information, we will make reasonable efforts to tell others, including people you name, of the changes in any future sharing of that information.

5. QUESTIONS AND COMPLAINTS

If you have any questions about this notice or if you think that we may have violated your privacy rights, please contact us. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services. We will not retaliate in any way if you choose to file a complaint.

BARRY J. LIBERONI, M.D., P.A.
720 AVENUE F, NORTH
BAY CITY, TEXAS 77414
(979) 245-9797

PRIVACY PRACTICE ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have viewed the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____

Birthdate _____

Signature _____

Date _____