Thomas K. Alexander, M.D.
Trung N. Dao, M.D.
399 W. Campbell Rd. #212
Richardson, Texas 75080

Acknowledgement Form

I,______________________________, acknowledge and have been made aware of this Notice of Privacy Rights in which I may review. I give my permission to Dr. Thomas K. Alexander or Dr. Trung N. Dao to use and disclose my health information in accordance with it.

Consent for Treatment

I,______________________________, acknowledge the need for medical care and hereby request and voluntarily consent to receive the usual medical services as well as the diagnostic procedures and medical treatment. **I understand that there is no guarantee as to the outcome or results of the treatments or examinations received.**

Confidentiality

I acknowledge that any and all medical care that I receive at this clinic will be treated with the utmost confidentiality. However, to facilitate my medical care, I hereby authorize Dr. Thomas K. Alexander or Dr. Trung Dao to provide information about my treatment and medical condition to the following individuals:

______________________________ ______________________________
Name Relationship Name Relationship

______________________________ ______________________________
Name Relationship Name Relationship

______________________________ ______________
Patient Signature Date

______________________________ ______________
Witness Signature Relationship