MEDICAL CONSENT: I consent to the provision of health care services with this health care provider and request my health care provider to provide any care they think is necessary and consistent with my instructions. I understand this care may include tests, examinations and medial treatment. I acknowledge that the health care provider treating me may be an independent contractor, and that no guarantee has been made to me as the results that may be obtained from this examination or treatment. If the health care services I am requesting require multiple visits, I consent to all necessary routine treatment ordered by my health care provider will discuss this with me and my additional consent will be required. I understand I may revoke my consent at any time. However, action taken by this health care provider before that time will remain covered by this authorization.

AUTHORIZATION TO RELEASE INFORMATION: I authorize this health care provider to release from my medical record any information requested or required by my insurance carrier, government agency or any entity responsible for processing or paying my claims for medical benefits. This consent is valid for the life of the claim. I authorize information from my medical record to be reviewed by employees of my insurance company, their agents or my health care providers. If I have been referred to another health care provider, I authorize this health care provider to release a copy of my medical record, or any part of my medical record, for the purpose of providing continuing care. I have read and fully understand the above information, have asked questions about anything not clear to me and am satisfied with the answers I have received. I understand I may revoke this consent at any time.

_____**YES, I** have received the HIPPA Notice of Privacy Practices

_____ _____
Patient's Signature Date

``**SIGNATURE OF PATIENT'S REPRESENTATIVE:** (Complete this section if patient is unable to consent or a minor under 15 years old). ***I certify that I am legally authorized to consent on behalf of the patient: The physician of this practice is authorized to treat this patient in my absence.***

Reason patient is unable to consent:_____

_____ _____
Patient's Representative Relationship to Patient