CONSENT AND RELEASE FORM

PATIENT PRINT NAME: _____DOB:_____

CONSENT FOR MEDICAL TREATMENT

I voluntarily present for treatment and consent to my physician and whomever they may designate, associate, treating physician and patient care staff to provide my care. Such care may include, but not be limited to, diagnostic procedures, psychotherapeutic treatment, other treatments and medications, pathologic and radiological evaluations and procedures considered advisable in my diagnosis, treatment and course of care.

I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations at Advanced Urgent Care.

_____ _____
Patient/Guardian/Guarantor Signature Date

_____
Patient's Printed Name

RELEASE AND USE OF PATIENT INFORMATION

In addition to the release and uses of my health information described in the HIPAA Notice of Privacy Practices, I authorize the release of my medical records, information, treatment and advice, and specific health information to:

_____
Name Relationship Phone
Check Here □ if you choose the same person as your emergency contact.

I understand the information concerning medical care, advice or treatment may include: history, physical, diagnosis, laboratory and diagnostic testing, specific information concerning alcohol abuse, mental health, drug abuse, human immune-deficiency virus, hepatitis, or other infectious diseases.

I understand that I have the right to revoke this authorization.

_____ _____
Patient/Guardian/Guarantor Signature Date

_____
Patient's Printed Name

I, hereby, revoke the above Release and Use of Patient Information authorization.

_____ _____
Patient/Guardian/Guarantor Signature Date

_____
Patient's Printed Name