Patient Print Name: ___________________________________ Date: ______________________

CONSENT AND RELEASE FORM

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 Medical Center.

____ ____________________________
Patient/Guardian/Guarantor Signature Date

____ ____________________________
Patient's Printed Name Date

RELEASE AND USE OF PATIENT INFORMATION

I authorize the release of my medical records, information, treatment and advice, and specific health information to:

1. An EMPLOYER who requests services (including history, physical, laboratory and diagnostic tests and screening for the presence of drugs, alcohol or marijuana.)
2. EDUCATIONAL OR SCIENTIFIC INSTITUTIONS authorized healthcare professionals in training, internal quality improvement, risk management and legal counsel when it is judged that my ongoing medical care, medical research, quality improvement, healthcare education or science will benefit; for any purpose authorized by law.
3. TREATING PHYSICIANS on staff at Advanced Medical Center, their agents and allied health professional; to another healthcare facility upon direct transfer and to my attending consulting, referring and/or primary care physicians for follow up care. I understand that if I refuse to authorize access to my records for coordination of care, my treatment could be adversely affected.

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