



Consent for Treatment/Privacy Notice

Name _____ DOB _____

- A. **Consent for Treatment:** I give consent to my physician and his assistants to provide me with such medical, surgical, diagnostic, or other treatment services necessary and/or appropriate. This consent includes diagnostic procedures and all medical treatment rendered at my physician's office under his/her instruction: including laboratory procedures, treatments, monitoring and all other procedures or treatments that do not require my specific informed consent. I understand that in the course of diagnosis and treatment cells, tissues, and/or parts may be removed from my body for further testing. Further, I agree to the use of anesthetic, sedatives and other medications as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.
- B. **General Acknowledgments:** I understand that the practice of medicine and surgery is not an exact science. I understand that medical and surgical treatment and diagnosis may involve risks of injury and even death. No guarantees have been made to me with respect to the results of my examinations or treatments. I understand that it is my responsibility to follow instructions and make arrangements for follow-up care as directed by my physician. I understand that I may review and obtain a copy of my medical record, at my own expense, and that this review shall take place during regular business hours.
- C. **Privacy Notice:** I acknowledge that I was provided with and had an opportunity to read a copy of the Notice of Privacy Practices – which includes the Federal Health Insurance Portability and Accountability Act (HIPAA). Please refer to the Notice of Privacy Practices for more information regarding release of your health information and your right to access your health information.

Signature of Patient/Authorized Representative

Date