Consent For Medical Treatment

I understand that my health condition may require diagnosis and treatment. I hereby voluntarily consent to such treatment, services, and procedures as ordered by my provider, his/her consultants, associates and assistants, or his/her designee. I also understand student Nurse Practitioners and others in professional training programs may be among the individuals who provide care to me.

_____

Signature of Patient/Legally Authorized Representative Date

Permission to Verbally Discuss Protected Health Information

I give permission to Your Healthcare Place to VERBALLY discuss the following medical and billing information about me (check all that apply):

- ☐ Appointment Information
- ☐ Medical information including my symptoms, diagnosis, medications and treatment plan
- ☐ Behavioral health information including my symptoms, diagnosis, medications and treatment plan
- ☐ Chemical dependency information including my symptoms, diagnosis, medications and treatment plan
- ☐ Lab/test results
- ☐ Billing and payment information
- ☐ Other: _____
  _____

Your Healthcare Place has my permission to discuss the above information with:

Name: _____ Relationship_____

Street Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell Phone: _____

Name: _____ Relationship_____

Street Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Cell Phone: _____

_____

Signature of Patient/Legally Authorized Representative Date