CONSENT TO CARE AND AUTHORIZATION FOR RELEASE OF RECORDS

CONSENT TO CARE. I consent to receive such routine medical care and diagnostic procedures as are deemed necessary by the Physician and his/her designees (herein referred to as "the Physician"). I also consent to the administration of such drugs and therapeutics as may be ordered by the Physician. I authorized the Physician and his/her designees to obtain specimens of blood, urine and other body fluids, tissues or products for the purpose of tests and procedures as deemed appropriate by my Physician, and to dispose of same.

CONSENT TO USE OR DISCLOSE OF HEALTH INFORMATION. I understand that it is the intent of this medical practice to hold all of my individually identifiable health information (medical information) with the utmost level of confidentiality. I consent to my Physician and his/her designees and other healthcare providers using or disclosing my individually identifiable health information for treatment, payment, healthcare operations, and as described in the Physician's Privacy Notice. I consent to the Physician and his/her designees disclosing my individually identifiable health information (medical information) to Jackson Community Medical Record, LLC, for treatment, payment or healthcare operations, including for my continuing care and treatment.

AUTHORIZATION FOR RELEASE OF INFORMATION. I authorize the release and disclosure of any medical information necessary to process my insurance claim(s) to the providers listed above and I authorize payment of medical benefits to be made to the above provider(s) for services rendered. I authorize the release and disclosure of individually identifiable health information (medical information) to Jackson Community Medical Record, LLC.

I understand that medical information may be released to my employer if this is a work related condition, and authorize this release of medical information to my employer I understand that only information related to the injury may be released.

I understand that the policy of this office is to charge at the physician's discretion, for medical advice given over the telephone. Most insurance companies will not pay for this charge. I am responsible if my insurance company does not cover this charge.

I understand that I am ultimately responsible for payment of services that are rendered to me. I understand that the above listed provider will bill my insurance company but that I am responsible for any balance that my insurance company does not pay and for any and all co-payments or deductibles.

NO GUARANTEES OR ASSURANCES. I am aware that the practice of medicine is not an exact science, and I acknowledge that the Physician has made no guarantees or assurances as to the results that may be obtained or the consequences that may follow concerning any treatment or services that I received from the Physician and his designees. I understand that I will receive the usual and ordinary care rendered in this community and that no other contract, written or implied, is being made.

I have read this form in its entirety or have had it read to me. Additionally, I have had the opportunity to ask any questions that I may have and they have been answered to my satisfaction

Signature: _____ Date: _____

Printed Name: _____