ROMEO MEDICAL CLINIC POLICIES AND PROCEDURES

I authorize the physicians and other health professionals who care for me at Romeo Medical Clinic to perform or order diagnostic procedures and to provide medical treatment as necessary in their professional judgment. I am aware that the practice of medicine is not an exact science and I acknowledge that there are no guarantees as to the outcome of any procedure. I understand that I have opportunity to ask question that I have regarding my diagnosis and plan of treatment. I have received a copy of the policies and procedures of Romeo Medical Clinic and agree to follow all policies and procedures as outlines in the patients guide given to me including but not limited to HIPAA Privacy rights, patients rights and responsibilities, and missed appointment fee policy.

Printed name of Patient: _____

Signature of □ patient □ parent □ legal guardian

_____ Date: _____/_____/_____

PERMISSION TO CONSENT FOR CARE

I authorize the following: □ minor patient

Name: _____Phone (____) ____-_____Relationship: _____

Name: _____Phone (____) ____-_____Relationship: _____

To consent to any treatment rendered on the advice of any physician or other health care professional licensed to practice medicine at Romeo Medical Clinic.

Signature: □ patient □ parent □ legal guardian

_____ Date: _____/_____/_____

AUTHORIZATION TO RELEASE HEALTH INFORMATION

I authorize Romeo Medical Clinic to discuss/release my health information with the following person(s):

Name: _____Phone (____) ____-_____Relationship: _____

Name: _____Phone (____) ____-_____Relationship: _____

This information includes but is not limited to appointment changes/ verifications, laboratory and diagnostic testing results, and medication updates.

□ I would NOT like Romeo Medical Clinic to discuss my health information with anyone but myself.

Signature: □ patient □ parent □ legal guardian

_____ Date: _____/_____/_____

Submit via Email