AMD Primary Care

Patient Consent Form

CONSENT FOR TREATMENT

I, ________________________________ (please print name) am voluntarily seeking medical care and treatment from AMD Primary Care, a private primary care practice. I give permission to the medical and ancillary support staff of AMD Primary Care to examine me, make diagnoses, and provide treatment to me in accordance with the information, explanations and recommendations they provide me.

CONSENT TO OBTAIN MEDICAL RECORDS

I, ________________________________ (please print name) voluntarily consent and authorize AMD Primary Care to obtain my protected health information during the term of this authorization.

Term: I understand that this authorization will remain in effect until the responding provider fulfills this request.

Information to be disclosed: I authorize the release of:

- **All provider care notes, laboratory and imaging results from the last 12 months**

Refusal to sign/right to revoke: I understand that signing this form is voluntary and that if I don't sign, it will not affect the commencement, continuation or quality of my treatment at AMD Primary Care. If I change my mind, I understand that I can revoke this authorization by providing a written notice of revocation to this office. The revocation will be effective immediately upon receipt.

Name: ______________________________

Signature: ___________________________ Date: _________________