ADVANCED RELIEF INSTITUTE

General Consent and Authorization for Treatment, Evaluation and Release of Information.

GENERAL CONSENT:

This Consent provides us with your permission to perform reasonable and necessary medical information, testing and treatment. The consent will remain fully effective until it is revoked in writing. You have the right to discontinue services at any time. I certify that my medical history is complete and accurate to the best of my knowledge and ability. I consent to reasonable and necessary medical examination, evaluation, testing and treatment which medical diagnostic, radiology and laboratory procedures. If invasive interventional treatment is recommended, I will be informed of the benefits and risks prior to performance of such treatment and will be provided with a separate consent form outlining such benefits and risk.

PROTECTED HEALTH INFORMATION:

The Notice of Privacy Practices for Advanced Relief Institute has been provided to me. I understand I have the right to review the Notice of Privacy Practices for Advanced Relief Institute which describe the types of uses and disclosures of my protected health information that will occur in the treatment, payment of my bills, or the performance of Advanced Relief Institute's operations. A summary of the Notice of Privacy Practices for Advanced Relief Institute is also posted in the waiting room. This Notice of Privacy Practices for Advanced Relief Institute also describes my rights and duties of Advanced Relief Institute with respect to my protected health information. Advanced Relief Institute reserves the right to change the Privacy Practices that are described in the Notice of Privacy Practices for Advanced Relief Institute. I may obtain a revised Notice of Privacy Practices for Advanced Relief Institute by contacting the office by phone email or patient portal.

RELEASE OF INFORMATION:

I specifically authorize the uses and disclosures of my health information as described in the Notice of Privacy Practices provided to me. I authorize Advanced Relief Institute, Dr. Amin, Dr. De Souza, Dr. Broyer, Dr. Paglia, and/or the staff, to obtain my medication history and other relevant healthcare information, verbally, written or electronically, that is deemed necessary for my treatment. I consent to release of my health information to federal or state health plans, insurance companies, collection agencies, employers or other organizations responsible for payment of services, as appropriate. I understand that this may include information relating to my diagnosis, care, payment for my care, or demographic information.

BY SIGNING BELOW, I AM AGREEING TO THE CONSENTS AND RELEASES DESCRIBED ON THIS FORM. I HAVE READ THIS CONSENT AND HAVE BEEN ABLE TO ASK QUESTIONS.

ADVANCED RELIEF INSTITUTE

Patient Printed Name: _____ Current Date: _____

_____
Signature

Patient Signature