AUTHORIZATION TO CONSENT TO TREATMENT
ADULT

FOR PATIENTS 18 YEARS OF AGE:

I, _____, being 18 years of age or older, authorize the people listed below to have access to my personal health information. This authorization will remain in effect until I notify the physician's office of a change.

I understand that with my signature I am authorizing the release of any information in my medical record to any people listed below.

Print the name of all that can have access to my personal health information:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

_____No access allowed to anyone but myself **YOUR Cell Phone #: _____**

YOUR Email: _____

How should we contact you? Please check ONE preference for each line:

Medical Issues:	___Call Cell	___Text to Cell		___Email
Appt Reminders:	___Call Cell	___Text to Cell		___Email
Reminder to Schedule Needed Appts:	___Call Cell	___Text to Cell		___Email
Billing Statements:	___Call Cell	___Text to Cell	___Mail to Home Address	___Email
Patient Portal Notification:	___Call Cell	___Text to Cell		___Email

X_____

Signature of Patient Date

Advance Practice Nurse (i.e., Nurse Practitioner)

This office has on staff an advance practice nurse to assist in the delivery of medical care. An advance practice nurse is not a doctor. An advance practice nurse is a registered nurse who has received advanced education and training in the provision of health care. An advance practice nurse can diagnose, treat, and monitor common acute and chronic diseases as well as provide health maintenance care. In addition, the advance practice nurse may treat minor lacerations and other minor injuries.

I have read the above, and hereby consent to the services of an advance practice nurse for my health care needs. I understand that at any time I can refuse to see the advance practice nurse and request to see a physician.

X_____

Signature of Patient Date