GENERAL CONSENT TO TREATMENT

Date:__________________________________

Patient Name:____

1. CONSENT: I request and authorize care as my physician and his/her designees and assistant may deem necessary or advisable. This includes, but is not limited to, routine diagnostic and laboratory procedures, administration of drugs and other therapeutics, and routine medical, nursing, and hospital care.
2. RELEASE OF INFORMATION: I understand that the confidentiality of all medical records will be protected to the full extent of the law. I authorize Newland Medical Associates, P.C. to release all information from my medical record to:
    a. Any referring or primary care physician, or any health care facilities or physician to which I am referred for the purpose of continuity of care;
    b. Any third party payors, organizations or insurance companies which are responsible, in whole or part, for obtaining third party insurance benefits for me, for billing and/or paying my physician, and for filing appeals of denial of benefits, so that Newland Medical Associates, P.C. may be paid for the services provided to me; and
    c. Any independent auditors or review agencies retained by any third party payors and insurer to analyze the charges for services rendered to me.
1. NO GUARANTEES: I am aware that the practice of medicine is not an exact science. I acknowledge that no guarantees or promises have been made to me as to the results of the care and treatment, which I have authorized.
2. TESTING AND DISPOSAL OF SPECIMENS AND TISSUES: I authorize Newland Medical Associates, P.C. to retain, preserve, or use for research, scientific or teaching purposes or to dispose of any specimen or tissue remaining after completion of a clinical procedure or treatment.