Consent to Treatment & Authorization for Release of Healthcare Information

Patient Name	
Date of Birth	
Social Security	
Today's Date	
Phone Number	
Address	

I, ___________________________ hereby voluntarily consent to treatment from NJ Medivisits™, encompassing routine diagnostic procedures, examination and medical treatment including, but not limited to, routine laboratory work (such as blood, urine and other studies), taking of x-rays, EKGs, or ultrasound imaging, and administration of oral or injectable medications prescribed/ordered by the physician.

I authorize NJ Medivisits™ to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare or any other third-party payers. I authorize NJ Medivisits™ to release all medical information to my referring physician and my primary (family) physician. I authorize NJ Medivisits™ to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy. I direct the insurance company or health plan administrator to release such information to NJ Medivisits™. I request and authorize that my health care information and any pertinent medical records (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) be released to NJ Medivisits™.

NJ Medivisits™ acts in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), this information has been provided to me.

I understand that this consent form and authorizations will be valid and the provisions listed above will remain in effect as long as I receive medical care from NJ Medivisits™, or until I provide written revocation.

This form has been explained to me and I fully understand and agree to its contents.

Signature of Patient/Legal Guardian: ____________________________

Signature of Closest Relative/ Legal Guardian*: ____________________________

Signature Witness: ____________________________

Date: ____________________________

*If the patient is unable to consent, please complete the following:
1) Patient is a minor and is ______ years of age.
Name of Father _________________________
Name of Mother _________________________
2) If patient is an adult, list reasons why he/she is unable to consent: ____ ______