Patient Consent

Request for Care and Consent for Treatment

The undersigned consents to the medical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider, which may include but are not limited to laboratory procedures, X-ray examination, medical or surgical treatment or procedures or other services rendered to the patient under the general and special instructions of the patient's physician. Gastro Florida has the right to refuse to treat you if you refuse to sign this consent or if, at any time, you choose to revoke this consent.

Assignment of Insurance Benefits

I authorize payment directly to Gastro Florida of any insurance benefits otherwise payable to me for services, at a rate not to exceed Gastro Florida regular charges for such services**.**

Authorization to Release Information

I authorize the release of medical records and related information from Gastro Florida to authorized representatives of my third party payor or physician related to my care. I authorize review of records for any necessary agency audit and the release of the physician plan of care and discharge summary from my medical record upon my transfer to or from another health care facility.

Permission for Treatment

Permission is hereby granted for physicians and employees or agents of Gastro Florida to render such medical and surgical treatment as is deemed necessary to the patient named below.

The undersigned certifies that he/she has read the foregoing, received a copy thereof and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms.

_____ _____

Patient/ Guardian Signature Date

_____

Printed Name of Person Signing Consent Form

If other than the patient (Patient Name)_____ is signing, are you the legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations? ☐ Yes ☐ No