Hunt Regional Medical Partners

PATIENT CONSENT FORM

PATIENT CONSENT FOR TREATMENT

1. I voluntarily consent to any and all healthcare treatment and diagnostic procedures provided by Hunt Regional Medical Partners and its associated physicians, clinician and other personnel. I am aware that the practice of medicine and other healthcare professionals is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations.
2. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and healthcare operations consistent with the Hunt Regional Medical Partners Privacy Practices.
3. I authorize payment of medical benefits to Hunt Regional Medical Partners or their designee for services rendered.
4. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

_____ _____

Signature of Patient or Patient Representative Date

PATIENT MEDICATION CONSENT

I do hereby give Hunt Regional Medical Partners consent to access my medication history electronically.

I understand that electronically accessing my medication history allows my doctor to receive critically important information on my current and past prescriptions and to become better informed about potential medication issues.

Pharmacy Name(s): _____

_____

Pharmacy Location and Phone Number (if known): _____

_____

_____

_____ _____

Signature of Patient or Patient Representative Date