Medical Release Form

Patient Information

Patient Name: _____

Date of Birth:____/_____/_____ SSN:_____

Address: _____ City: _____

State:_____ Zip Code:_____ Phone: (____)____-_____

Email:_____

Information Requested From:

Name: _____

Address: _____ City: _____

State:_____ Zip Code:_____ Phone: (____)____-_____

Email:_____ Fax: (____)____-_____

Send Information To:

Send by: • Mail • Secure Email • Fax

Name: Olive Health

Address: 4812 W Trapnell Rd, Plant City, FL 33566

Phone: (813) 417-4767

Email: Frontdesk@olivehealthfl.com

Fax: (888) 814-0945

I hereby grant permission for you to release confidential health information about me, by releasing a copy of medical record, or a summary or narrative of my protected health information to the physician/facility/entity identified above for _____ (Patient Name).

Signature: _____

(Patient,Parent,Guardian POA, Health Care Surrogate)

Date: _____

Consent to Treat Form

1. I give permission for **Olive Health, LLC** to give medical treatment to _____ (patient name).

2. I allow **Olive Health, LLC** to file for insurance benefits to pay for the care I receive. I understand that:
   - **Olive Health, LLC** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

By affixing my signature below, I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Patient, Parent,Guardian POA, Health Care Surrogate Signature

Date

_____

Name