DMG
DISTRICT MEDICAL GROUP

Consent for Treatment

_____ General consent: I consent to medical care at this facility, including telephonic evaluation and management if medical services are not performed in-person. I hereby authorize medical treatment by the physician, the clinical staff and technical employees assigned to my care. I authorize my treating providers to order any ancillary services deemed necessary for my care and treatment.

_____ I understand that I have the right and the opportunity to discuss alternative plans of treatment with my physician or other healthcare provider and to ask and have answered to my satisfaction any questions or concerns.

_____ In the event that a healthcare worker is exposed to my blood or body fluid in a way which may transmit HIV (human immunodeficiency virus), hepatitis B virus or hepatitis C virus, I consent to the testing of my blood and/or body fluids for these infections and the reporting of my test results to the health care worker who has been exposed, as required by Arizona law.

_____ I understand that District Medical Group utilizes an electronic medical record system. I understand that this system is maintained in accordance with HIPAA and other patient privacy and health information management regulations. I understand that my healthcare providers will have access to my healthcare information across the continuum of my care.

_____ I understand that District Medical Group utilizes an electronic prescribing mechanism for electronic transmission of prescriptions to local pharmacies and mail order pharmacies.

_____ I consent to the release of my prescription history from any pharmacy or drug monitoring agency to my physician or provider.

By signing this document, I agree that photocopies of this document are as legally binding as the original.

I have read and understand and agree to the above terms.

_____ _____ _____ _____

Patient or Guardian signature Printed Name Relationship to Patient Date

PRIVACY AND DISCLOSURE OF MEDICAL INFORMATION

Our notice of Privacy Practices provides information about how we may use and disclose your personal health information. By signing below, you acknowledge that you have received a copy of our use and disclosure form.

_____ _____ _____ _____

Patient or Guardian signature Printed Name Relationship to Patient Date