FAMILY CHOICE MEDICAL CLINIC, P.A.

PATENT INFORMED CONSENT MINOR OFFICE SURGERY/PROCEDURE

PATIENT NAME: _____

1. I, _____, (patient or guardian) authorize:
   Dr. _____ and any assistant (s) he/she deems necessary to perform the following procedure: _____
2. I understand that the procedure involves the following: _____
   _____
   I further direct that any tissue(s) removed be disposed of by Family Choice Medical Clinic, P.A. in accordance with acceptable practice.
3. **RISKS:** Possible complications of this procedure include, but not limited to bleeding, scarring and/or other changes, and infection.
4. Anesthesia: The administration of anesthesia or pain relief medications that may be administered also involves serious risks, most importantly a rare risk of reaction to medications causing death. I consent to the use of such anaesthetics and medications as my be considered necessary by the person responsible for performing this procedure, except: _____
5. Results not Guaranteed: I understand that no guarantee or assurance has been made to me as to the results of the procedure and that it may not cure the condition. Alternatives are: _____
6. I have read and fully understand this consent form, and understand that I should not sign this form if all items, including my questions, have not been answered to my satisfaction or if I do not understand any of the term of words contained in this consent form.
   IF YOU HAVE ANY QUESTIONS AS TO THE RISKS OR HAZARDS OF THE PROPOSED PROCEDURE OR TREATMENT, OR QUESTIONS CONCERNING THE PROPOSED PROCEDURE OR TREATMENT, ASK YOU PROVIDER NOW, BEFORE SIGNING THIS FORM. DO NOT SIGN UNLESS YOU HAVE READ AND THOROUGHLY UNDERSTOOD THIS FORM.

(Witness) _____ (Patient/Responsible Party) _____

Date: _____ Time: _____

7. **PROVIDER DECLARATION**
   I have explained the contents of the document to the patient and have answered all the patient's questions. To the best of my knowledge, I feel the patient has been adequately informed and had consented.

Provider's Signature _____ Date _____ Time _____

FAMILY CHOICE MEDICAL CLINIC, P.A.

PATIENT NAME: ---------- DATE OF BIRTH: ----------

CONSENT FOR THREATMENT OF A MINOR

This is to authorize and consent to any necessary or routine medical or minor surgical treatment including examination, injection, immunization, and/or diagnostic procedures, including x-ray and laboratory analysis. I understand that only myself, and those listed below will have the authority to authorize treatment.

NAME	RELATIONSHIP TO PATIENT
_____	_____
_____	_____
_____	_____
_____	_____

Any person bringing the patient in for treatment not listed above must have a dated and signed letter of consent from me, or treatment could be refused or delayed. I understand that in unusual circumstances, efforts will be made to contact me prior to the rendering of treatment, but that medical treatment will not be withheld if I cannot be reached. This authorization will remain in effect unless so designated that such consent for treatment of minor is cancelled. I have read all the information on this sheet and have completed the above answers. I certify this information to be true and correct to the best of my knowledge. I will notify Family Choice Medical Clinic of any changes to this information in the form of a signed and dated letter.

Printed Name _____

Signature_____ **Date** _____

AUTHORIZATION TO RELEASE MEDICAL RECORDS

Patient's name: _____ Patient's Date of Birth: _____

Patient's Social Security Number: _____
Parent or Guardian's Name: _____
I hereby authorize: _____
City: _____ State: _____
Phone: ( ) _____Fax:( )_____

To release any and all information to _____, pertaining to the aforementioned patient, including diagnosis and medical records of any/and all treatment(s) and/or examination(s) rendered to the patient named above, to include but not limited to any Federal and State protected documents under Florida Statute 394.459(9)Psychiatric records; Florida Statute 397.053 and Florida Statute 396.112.Drug or Alcohol abuse records; Florida Statute 381.609(2)Human Immunodeficiency Virus test results(AIDS and related conditions). I am aware that the information released pursued to this authorization is subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Rule.

PLEASE CHECK ONE

_____SEND ALL RECORDS

_____Send Discharge Summary only, for:
( ) All Hospitalization
( ) Hospitalization date(s) of : ___/___/___to___/___/___
_____Send Newborn Screen Only
_____Send Immunization Record only
_____Other_____

I understand that this authorization will expire in six months. I further understand that I may revoke this authorization at any time during this period by notifying the providing organization in writing.

Signature of parent/guardian: _____ Date:_____
Relationship to Patient: _____

Release to:

_____	_____
(Name of Doctor/Practice)	(Address)
_____	_____
(Telephone Number)	(City, State & Zip)

Or Fax To: (561) 828-8007