A D V A N C E D L I P I D O L O G Y

Early Detection Center for Heart Disease & Diabetes

Specializing in the Care of Men, Women, & Children

CONSENT FOR TREATMENT

Patient Name: _____ Date of Birth: _____

I hereby authorize and consent to the performance of routine examinations, diagnostic procedures, and treatments, which my attending physician and I agree are necessary. This consent does not apply to vaccinations and non-routine treatment or procedures. This consent shall remain in effect until I choose to revoke it in writing.

Minor consent: This consent is effective even if I am not physically present during my child's treatment. I agree to immediately notify Advanced Lipidology, in writing, of any of the following legal status changes between my minor child and myself:

- Loss of parental rights
- Changes in guardianship
- Divorce with loss of visitation rights

Parent/Guardian signature required if patient is under age 18

_____ _____

Patient signature Date

_____ _____

Parent/Guardian signature Date

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize and give my permission for Advanced Lipidology to release information to myself and to my primary physician and/or referring physicians. Information may include lab results and office visit notes. I understand that authorizing the disclosure of this medical information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment, enrollment, or eligibility for benefits. I understand that any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. I fully understand that my medical record and information in connection with the treatment may include reference to treatment of alcohol and drug abuse, psychiatric care, developmental disabilities, HIV test results/acquired immune deficiency syndrome, intoxication tests, and/or fetal monitor tracings. I understand that a photocopy shall be considered as valid as the original. I may inspect and arrange for photocopies of the information that is to be disclosed. I understand that I have a right to revoke this authorization at any time by providing written notice to the medical record department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company as needed to contest a claim under my policy. I understand that a fee may be involved if I need a complete copy of all my records for personal use or insurance company needs.

_____ _____

Patient signature Date

_____ _____

Parent/Guardian signature Date