Authorization to Treat Form

Patient Name_____ Phone_____ Date of Birth_____

Mobile Phone_____Email Address _____

Authorization to Treat

1. I consent to allow WellBe Senior Medical to provide diagnostics and other healthcare related services. I understand that these services may include examinations and treatments.
2. I understand that WellBe Senior Medical providers will not provide any guarantees to me as a result of treatment and/or examinations.
3. I acknowledge and understand that my medical information may be released to other physicians, institutions, or agencies accepting me for medical or institutional care. Additionally, I acknowledge and understand that my medical information may be released to my health plan or other entities for treatment, payment or healthcare operations and that data (medical or personal) may be released to such government agencies as is required of the medical providers of WellBe Senior Medical by law, rules, regulation or by contract.
4. I understand that the laws that protect the confidentiality of my medical information also apply to Telemedicine, and that no information obtained which identifies me will be sold, shared, or disclosed to other entities without my consent.
5. I acknowledge that I have received a copy of the WellBe Senior Medical's Notice of Privacy Practices.
6. I agree that a photocopy of this consent is as valid as the original.

_____ _____ _____

Signature of Patient and/or Designated Power of Attorney | Relationship to Patient | Date

Authorization for Telemedicine/Telehealth

I consent to participate in a telemedicine consultation/visit, and specifically acknowledge and consent to the following:

1. During the telemedicine consultation/visit, details of my medical history, examinations, x rays and tests will be discussed through the use of interactive audio, video, and/or telecommunication technology. A physical examination of me may take place.
2. Video, audio, and or photo recordings of me may be taken to document my medical condition during this visit.
3. The risks and benefits of telemedicine have been shared with me, including the limitation of evaluation and management. I have been offered an in-person visit. I consent to proceed with the use of telemedicine for my visit and examination.

_____ _____ _____

Signature of Patient and/or Designated Power of Attorney | Relationship to Patient | Date

Medical Record Release

By signing this form, I authorize the release of my medical records or other health care information, including chart notes, reports, correspondence, and other written information concerning my health and treatment, to WellBe Senior Medical.

_____ _____ _____

Signature of Patient and/or Designated Power of Attorney | Relationship to Patient | Date