CONSENT FOR TREATMENT AND MEDICAL INFORMATION RELEASE FORM

I authorize the examination and treatment of ____by Shelly L. Hall M.D., PA, medical staff, and such associates they deem necessary. I understand that the examination may include the use of x-rays, laboratory tests, photographs and other n on-invasive diagnostic procedures and tests normally provided in a clinic or health facility.

I understand that should more specialized tests and procedures be required, these will be explained by the physician or his/her designee and my consent shall be obtained.

I hereby authorize Shelly L. Hall M.D., P.A. and any other health care provider(s) so indicated, ________ ____to release and exchange all pertinent medical records regarding me or my child's treatment and/or AIDS or testing for AIDS (HIV), to appropriate consulting medical personnel without the necessity of obtaining further permission from me. If I do not authorize the release of this information, I understand the continuity of care could be effected. I agree to assume all responsibility from my refusal to exchange this information and also agree not to hold my physician(s) or other personnel responsible for any adverse results from my refusal to release this information.

I authorize the release of information for processing health insurance claims, including drug and alcohol use, abuse, psychiatric evaluation/treatment and/or AIDS or testing for AIDS (HIV). If I do not consent to the release of this information, I understand that I am personally responsible, or cause the responsible party to be liable, for all or any part of my bills for treatment and/or consultation.

All medical record information received/released by this office is protected by the state and federal confidentiality laws. Any further disclosure of this information is prohibited.

____ ____

WITNESS — PARENT/ADULT LEGALLY RESPONSIBLE FOR MINOR CHILD

____ ____

DATE TIME — DATE TIME

Other persons authorized to bring child in for MEDICAL treatment (does not include initial visit, well child visits, immunizations or any other invasive procedures):

____ ____

NAME — RELATIONSHIP

____ ____

NAME — RELATIONSHIP

____ ____

NAME — RELATIONSHIP

PATIENT: DOB: MED. REC.