**Consent to Medical Care and Treatment**

I consent to all medical and surgical care, examinations, and tests which are determined to be necessary for me, while I am a patient at this facility. I understand that the practice of medicine and surgery is not an exact science and that medical treatment may involve risks, injury, or even death. I acknowledge that no guarantees have been made to me as to the results(s) of any treatment, procedure, or examinations to be performed on me while I am a patient at this facility.

Signature Date

**Privacy Notice:**

I hereby acknowledge that a copy of the Notice of Privacy Policy was made available to me by Central Ohio Breast & Endocrine Surgery LLC on the date indicated below.

Signature Date

**Release of Information:**

In order to ensure patient confidentiality, it is the policy of this office to release information only to the patient. If you wish for others to receive ANY information regarding your care, you must sign this release. By signing this release, you are giving us permission to release medical information to your referring physician, your insurance company, and any other treating physicians, therapists, or hospitals.

Signature Date

If we are unable to reach you personally, do we have your permission to leave a message on your voicemail or answering machine?

YES NO

I give my permission for Central Ohio Breast & Endocrine Surgery to release my medical information to the following people (in addition to those listed above):

NAME RELATIONSHIP TO PATIENT

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