Addison Internal Medicine

Patient General Consent to Treat

I, _____ the undersigned, hereby consent to the following:

- Administration and performance of general treatments
- Use of prescribed medications
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory tests that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees.

I fully understand that this consent is given in advance of any specific diagnosis or treatment.

I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing.

I understand that Addison Internal Medicine may include consent at other satellite offices under common ownership.

A photocopy of this consent shall be considered as valid as the original.

Pharmacy Info/RX History Consent

We, at Addison Internal Medicine are very pleased that you have chosen us as your primary healthcare provider. In order to better serve you, your prescriptions will now be electronically processed directly to your pharmacy. Please provide us with your pharmacy information in the space provided below.

Pharmacy Name: _____

Pharmacy Address: _____

_____

Pharmacy Phone Number: _____

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

By signing this consent you are authorizing Addison Internal Medicine to view your prescription history from external sources.

_____ _____

Patient (or responsible party) Signature Date

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