CONSENT/NOTICE RECEIPT ACKNOWLEDGEMENT

Purpose: This form is used to confirm that an individual has received Metro Infectious Disease Consultant, Metro Infusion Centers, Metro Rheumatology, Travelers Medical & Immunization Service, and Metro Center for Health Notice of Privacy Practices.

I, ______________________________, acknowledge that I have received METRO INFECTIOUS DISEASE CONSULTANTS, METRO INFUSION CENTERS, METRO RHEUMATOLOGY, TRAVELERS MEDICAL & IMMUNIZATION SERVICE, AND METRO CENTER FOR HEALTH Notice of Privacy Practices. I have had full opportunity to read and consider the contents of this Notice of Privacy Practices.

I, ______________________________, hereby authorize my physician to administer to me any examination, treatment, and medications she/he deems therapeutic to my presenting complaint. I understand that my signature requests that payment be made and authorizes release of medical information necessary to pay the claim.

Signature: ______________________________ Date: ______________

(PLEASE PRINT)

Patient Name: ______________________________

Address: ______________________________

Telephone: ______________ E-mail: ______________________________

Patient Number: ______________ Social Security Number: ______________________

If this authorization is signed by a personal representative on behalf of the individual, complete the following:

Personal Representative's Name: ______________________________

Relationship to Individual: ______________________________