CONSENT

Treat & Release of Medical Records

Authorization for Treatment

I ____ the undersigned, hereby provide my informed consent to receive medical treatment and services from Infinite Health Care and it's Provider(s), hereinafter referred to as "the Provider". I understand that this consent encompasses any and all medical treatments, procedures, and services that the Provider(s) deems necessary or advisable for my health and well-being.

- Nature of Treatment: I understand that the Provider(s) will offer me appropriate medical treatment and services to address my health condition(s) to the best of their abilities. The specific treatment and services will be determined based on the diagnosis and assessment by the Provider(s).
- Risk and Benefits: I have been provided with information regarding the potential risks, benefits, and alternatives associated with the proposed treatments and services. I understand that the Provider(s) has answered my questions and addressed my concerns to my satisfaction.
- Consent for Medical Records: I authorize the Provider(s) to obtain and release my medical records as necessary for the continuation of my care and treatment, in accordance with applicable laws and regulations.
- Right to Refuse Treatment: I understand that I have the right to refuse any treatment or service recommended by the Provider(s). I acknowledge that by refusing recommended treatment, I may jeopardize my health.
- Privacy and Confidentiality: I understand that my medical information will be treated confidentially and in accordance with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable laws and regulations.
- Payment Responsibility: I agree to be responsible for payment for the medical services rendered to me by the Provider(s), including any services not covered by insurance. I understand that I may request an estimate of charges before any non-emergency treatment.
- Advance Directives: I have been informed of my right to create advance directives, such as a living will or durable power of attorney for healthcare, and the Provider(s) policy regarding such directives.
- Telemedicine: I understand that telemedicine services may be provided, and I consent to receive medical care through telemedicine if the Provider(s) deem appropriate.
- Minors and Dependents: For patients under 18 years of age or dependent adults, I represent that I have the legal authority to provide consent for their treatment. The undersigned warrants and represents that attached hereto are originals or certified copies of any applicable powers of attorney, health care surrogate forms or court orders appointing the undersigned as the legal guardian of the patient.

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Release of Information

This authorization, or copy of the same, authorizes the release to the Provider(s) of any medical information necessary for treatment and/or to process claims for services rendered by the Provider(s). The patient or authorized patient representative agrees to execute any documents and perform any acts the Provider(s) may reasonably request with regards to services.

Terms

This patient consent and authorization given to the Provider as set forth above will remain in full force and effect per episode of care until terminated in writing by patient or authorized patient representative. This termination will not be effective until the facility receives this request in writing.
I have had the opportunity to ask questions and clarify any concerns related to my treatment. I understand the information provided to me, and I freely and voluntarily consent to the proposed medical treatment and services.

Patient Consent

______________________________	______________________________
Signature of Patient or Patient's Representative	Date
______________________________	______________________________
Printed Name	Representative's Relationship to Patient