Fresh Start
Health and Wellness

Authorization of Treatment

I voluntarily consent to examination and treatment.

I hereby agree to diagnosis and /or treatment by Fresh Start Health and Wellness physicians and other paramedical personnel for my medical treatment.

I voluntarily consent to diagnosis and /or treatment. I understand that for the purposes of this consent, "medical or diagnostic procedures" include routine diagnostic examinations, x-rays, communicable disease screening, and other medical treatment normally attendant in outpatient care.

Release of Information

I authorize Fresh Start Health and Wellness to release any medical information necessary to process my medical claims. If my medical service resulted from a work-related injury or illness, I authorize the written and/or verbal release of information concerning the treatment of my work injury to my employer and employer's insurance company.

I authorize Fresh Start Health and Wellness to access my medication history through Sure Scripts "if applicable".

By signing below I certify that I have read these four agreements and/or that they have been fully explained to me, that I understand their contents and that I am the patient, or a person duly authorized to execute this agreement and accept all three agreement terms. I permit a copy of these authorizations to be used in place of the original.

PATIENT: _____ DATE:_____
PRINT NAME SIGNATURE

Relationship: _____ Patient's Date of Birth: ____/____/____

WITNESS: _____ DATE: _____
SIGNATURE