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PATIENT CONSENT

Consent for Treatment: I voluntarily consent to the rendering of care, including treatment and performance of the diagnostic procedure. I understand that I am under the care and supervision of the attending physician and it's the responsibility of the staff to carry out instructions of such physician.

Release of Information: By signing this form, you are granting consent to BROWARD OUTPATIENT URGENT CARE, LLC. to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by telephone our office at (888) 646-2273. You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant you request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Verification of non-pregnancy (female patients only)
By my signature on this form, I do herby state that to the best of my knowledge, I am not pregnant, nor is pregnancy suspected or confirmed at this particular time.

Date of last menstrual period____________________

____
Printed Patient's Name

____
Patient's Signature

____
Other than patient, print name & relationship

____
Witness