INFORMED CONSENT

I hereby request and consent to the performance of medical care and medical procedures, including various modes of interventional pain and management, joint and spine injections, and diagnostic procedure on me (or on the patient named below, for whom I am legally responsible) by the medical doctor/nurse practioner/physician assistant/medical assistant named below and/or other licensed doctors who now or in the future work at the clinic or office listed below or any other office or clinic affiliated with Empire Rehab.

I have had an opportunity to discuss with the medical provider named below and/or with other office or clinic personnel the nature and purpose of medical care and medical procedures. I understand that results are not guaranteed.

I understand and am informed that, as in the practice of medicine there are some risks to treatment, including but not limited to; temporary soreness or increased symptoms or pain. It is not uncommon for patients to experience temporary soreness or increased symptoms or pain after the first visit. Dizziness, nausea, and flushing: these symptoms are relatively rare. It is important to notify the medical provider and/or clinic if you experience these symptoms during or after your care. Fractures: When patients have underlying conditions that weaken bones, like osteoporosis, they may be susceptible to fracture. It is important to notify your medical provider if you have been diagnosed with a bone weakening disease or condition. If your medical provider detects any such condition while you are under care, you will be informed and your treatment plan will be modified to minimize risk of fracture. Disc herniation or prolapse. spinal disc conditions like bulges or herniations may worsen even with medical care. It is important to notify your medical provider if symptoms change or worsen. Stroke: A stroke may be associated with medical procedures. Other symptoms or outcomes associated with medical care and/or procedures may be, but not limited to the following: redness, itching, burning at site of injection; bleeding, bruising at site of injection; extremity weakness, numbness, tingling; paralysis; blood clot; death.

I do not expect the doctor to be able to anticipate and explain all risks and complications, and I wish to rely upon the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based upon the facts then known to him or her, is in my best interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its content, and by signing below I agree to the above-named procedures. I intend this consent form to cover the entire course of treatment for my present condition and for any future condition(s) for which I seek treatment.

Patient Signature_____ Date _____

Authorization to Disclose Health Information

Patient Name:_____ _____
Please Print (Last Name) (First Name)

Date of Birth ____/____/____ Social Security ____/____/____

1. I authorize the use or disclosure of the above named individual's health information as a described below:
2. The following individual or organization is authorized to make the disclosure:
3. The type and amount of information to be used or disclosed is as follows;(included dates where appropriate)

□ Emergency Records Date: _____
□ Operative Reports Date: _____
□ Admission Date: _____
□ X-ray & Imaging Reports Date: _____
□ Consultation Reports (Doctor's name) _____
□ Most Recent Discharge Summary
□ Laboratory Results
□ Entire Records
□ Other _____

4. I understand that the information in my health record may include information relation to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency (HIV). It may include information about behavioral or mental health services and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization.

NEW SOUTH MEDICAL

_____
(Name)

For the purpose of: Investigating and pursing a bodily injury case on my behalf.

1. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the relocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless other wise revoked, this authorization will expire on the following date, event or condition _____. If I fail to specify and expiration date, event or condition, this authorization will expire in six months.
2. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand I may inspect or copy the information to be used or disclosed, as provided in CFR164.524. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact NEW SOUTH MEDICAL director, privacy officer, or other office or individual's name or contact information.

Patient Signature: _____ **Date:** _____/_____/_____
Please Sign Here

Signature of Witness _____ _____
Please Sign Here If signed by legal representative, relationship