# CONSENT FOR TREATMENT

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, acknowledge the need for medical care and hereby request and voluntarily consent to receive the usual medical services as well as the diagnostic procedures and medical treatment. **I understand that there is no guarantee as to the outcome or results of the treatments or examinations received.**

# CONFIDENTIALITY

I understand that any and all medical care that I receive at the office of *Rajiv Joseph, MD, PA & Sleep Matters (“office”)* will be treated with the utmost confidentiality. However, to facilitate my medical care I hereby authorize the office to provide information about my treatment and medical condition to other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals. The following individuals may also receive information about my medical condition:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name Relationship Name of your Primary Care Physician

NOTICE OF PRIVACY PRACTICES

I understand that as part of my healthcare, Rajiv *Joseph, MD, PA & Sleep Matters (“office”)* originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations such as assessing quality and reviewing competence of healthcare professionals. Notice of Privacy Policies provides specific information and a complete description of how my personal health information may be used and disclosed. I have been provided a copy of or access to the Notice of Privacy Practices and understand that the office reserves the right to change the Notice of Privacy Practices. If changes are made to the Notice of Privacy Practices, they will be posted in the office where they can be seen, and I will have the opportunity to review the changes. I understand that I have the right to restrict the use/or disclosure of my personal health information for treatment, payment or healthcare operations and that the office is not required to agree to the restriction requested. I may revoke this consent at any time in writing except to the extent that the office has taken action in reliance on my prior consent. This consent is valid until revoked by me in writing.

I further understand that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.

Signature of Patient or Legal Representative Date:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name of Patient or legal Representative

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