



Consent to Treat

I, _____, hereby authorize and consent to the examination and/or treatment of myself during office and facility visits by the physicians and clinic staff of Sterling Health Solutions, Inc. (SHS). In the event of emergency or other illness, I understand that the physicians and staff of SHS will deliver any medical care deemed necessary.

In addition, I hereby give my permission for verbal or written communication concerning my healthcare and appointments to be shared with the following individuals (*include any interpreters that may be present during any visit to SHS*):

Name	Relationship	Phone Number

This consent will remain in effect until I revoke consent in writing to SHS.

Medical Records/Privacy

At SHS, we are committed to protecting the security and privacy of your personal information. Medical records are the property of SHS and kept in a secure location, and are accessed for only purposes outlined by the Notice of Privacy Practices. Records may be released or shared with other health care providers for your treatment. Patients are entitled to one free copy of their medical records only after an authorization for release is signed.

- I have received a copy of the Notice of Privacy Practices from SHS.
- I understand that SHS may call my home and place of employment for health care reasons, appointment reminders, and to resolve billing issues.
- I understand that SHS may use postcards to notify me of appointments or other pertinent information.
- I understand that SHS may fax immunization certificates, school excuses, physical/sports forms and/or medication to instruction to my personal or work fax if number provided or may mail to my home. SHS cannot fax or send these documents to third parties without separate authorization form(s).
- I understand that SHS may leave messages on my answering machine and/or voice mail regarding appointments and limited lab information
- I understand that SHS may discuss patient information with adults or minors (including interpreters) present during the visit.
- **I understand and agree to all of the above unless I strike through any of the statements.**

This consent will remain in effect until I revoke consent in writing to SHS.

Signature of Patient

Date