New Patient Intake Form – page 2

Patient Name: _____ Date: _____

CONSENT FOR MEDICATION HISTORY RETRIEVAL

I hereby authorize the Atlanta Oncology Associates and its affiliates to download my medication history electronically.

_____
Patient Initials

CONSENT TO OBTAIN/RELEASE MEDICAL RECORDS

I hereby authorize the AOA and its affiliates to obtain medical records from any other Physician or medical facility necessary in the course of my treatment. Additionally, I authorize the AOA and its affiliates to release any information acquired in the course of my treatment to other Physicians and medical facilities as needed. I authorize that this acquisition/release may occur by regular mail, fax or e-mail, as necessary. I also authorize the release of any information to a government agency (DEA, GBI, etc.) if requested by said agency.

_____
Patient Initials

CONSENT FOR TREATMENT

I hereby authorize any medical/surgical, x-rays, drug or laboratory tests, medications or exam as deemed necessary by the Physician, Physician Assistant or Nurse Practitioner. I understand that I may have the right to see a Physician if I chose and have the right to see the Physician prior to any prescription drug or devise order being carried out by a Physician Assistant. In case of an unemancipated minor, the consent below is given by his/her parent/guardian.

_____
Patient Initials

CONSENT TO EMAIL COMMUNCATION VIA PATIENT PORTAL

I hereby authorize AOA and its affiliates to use my email address given, to set up an account with MedFusion's Patient Portal on my behalf. I certify the email address provided is accurate, and that I, accept full responsibility for messages sent to or from this address. I understand I may receive my health record information via the patient portal. I agree to hold harmless the Provider, his/her medical practice, AOA and its affiliates and individuals associated with it harmless from any and all claims and liabilities arising from or related to communicating via email.

_____
Patient Initials

CONSENT TO RELEASE MEDICAL INFORMATION/RECORDS/ACCOUNT INFORMATION TO A *SPOUSE or FAMILY MEMBER/FRIEND*

I hereby authorize AOA and its affiliates to release any information contained in my medical records to the person or person indicated below:

YES _____, release to: _____ (please indicate relationship)

NO _____, release to only me.

By initialing the above items, I am stating that I have read the information contained therein. My signature below shows my acceptance of all items defined above.

_____ _____
Signature of patient or responsible party Date