Northeast Georgia
PHYSICIANS GROUP

ANNUAL CONSENT / AUTHORIZATIONS

Patient Name: _____ DOB: _____

Consent for Treatment:

- Permission is hereby given for any medical / surgical procedures, x-rays, drug or laboratory test, medication, or exam as may be deemed necessary by the Physician, Physician Assistant, Nurse Practitioner, or Nurse Midwife.
- I understand I have the right to see a Physician if I so choose, and have the right to see a Physician prior to any prescription drug or device order being carried out by an Advanced Practitioner.
- In the case of an unemancipated minor, the consent below is being given on his or her behalf.

Consent to Release Medical Information to a Spouse, Family Member or Significant Other:

Tell us with whom we may discuss your protected health information:
(Name and relation-Example: Jane Doe, Wife; Jan Doe, Daughter)

1) _____ 2) _____ 3) _____

- *If you do not authorize information to be released to anyone please check this statement.*

❑ **I do not authorize any information to be released to anyone other than myself.**

I hereby authorize messages to be left on a voice mail system or answering machine. Please indicate the number(s) NGPG staff can utilize to leave a message for you:

1) _____ 2) _____ 3) _____

- *For Medical Records release, see form C-45.*

Financial Responsibility:

I understand it is the responsibility of each patient to arrange for payment for the medical services received in this office. I hereby authorize any insurance benefits to be paid directly to Northeast Georgia Physicians Group, and recognize my responsibility to pay for all non-covered services. I also authorize the release of any information necessary to process an insurance claim. Charges for all minors are the responsibility of the parent, guardian, or individual presenting the child for treatment.

I hereby authorize Northeast Georgia Physicians Group, or any of its affiliates, agents, contractors or business associates, to contact me (by any telephone numbers, email addresses or other contact points provided by me or on my behalf) by the use of any automatic dialing system, by pre-recorded forms of voice/messaging systems, by electronic mail owned or used by the guarantor/responsible party, by text messages, by telephone or by cell phone for reasons related to the services I received at Northeast Georgia Physicians Group or payment for the services I received at Northeast Georgia Physicians Group including but not limited to, debt collection purposes.

Acknowledgment of Receipt of Nondiscriminatory Act Notice:

☐ By initialing, I acknowledge that I received a copy of the Nondiscriminatory Act Notice.

Acknowledgement of Privacy Rights:

By signing below I acknowledge that I am aware of the NGHS Notice of Privacy Practices and Individual Rights. We may use or share your medical information with personnel involved in your care at the Health System. We may also disclose your medical information to people outside of the System, such as Health Information Exchanges. NGHS Notice of Privacy Practices contains more information about the policies and practices protecting the patient's privacy.

I acknowledge that I have read the above, am giving my consent to the above, and am acknowledging I have been informed of my rights to privacy.

Signature: _____ **Date:** _____

Print Name: _____ **Email address:** _____