Center for Pediatric Adolescent Gynecology
Lawrence Amesse, MD, PA

CONSENT/RELEASE OF RECORD

Date: _____

Patient Name: _____ Unit #: _____

CONSENT FOR MEDICAL TREATMENT- I hereby authorize Atlantic Reproductive Associates and the physician(s) in charge of my care to administer any medical treatments and medications and to perform laboratory tests (including blood tests for any disease or condition) and diagnostic procedures as deemed necessary or advisable in my diagnoses and treatments. I understand that physician(s) will receive results of the tests and services ordered. I am aware that the practice of medicine, surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of treatments or examinations.

I authorize the release of any medical information necessary to process claims for payments, and for the purpose of obtaining authorization from insurance companies for further tests or treatment with any right to privacy waived including any treatment for mental illness, alcohol abuse, drug abuse or HIV.

I, the undersigned, certify that I have read the foregoing and am the patient, the patient's legal representative or duly authorized by the patient as the patient's general agent to execute the above and accept its terms. The undersigned also fully understand the contents of this form and voluntarily executes it.

Patient Signature _____ Date _____
(If other than patient, sign & state relationship)

Witness Signature _____ Date _____