Consent to Treat
Mal S. Riddell, D.O.

Patient Name: _____

Social Security Number: _____ Date of Birth: _____

I give Dr. Mal S. Riddell permission to render treatment and procedures by physicians, members of the house staff, and employees. The undersigned has read and understood this Consent to Treat and certifies that no guarantee or assurance has been made as to the results that may be obtained.

I understand that as part of my health care, Dr. Riddell 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 serves as:

1. a basis for planning my care and treatment
2. a means of communication among the many health professional who contribute to my care
3. a source of information for applying my diagnosis and surgical information to my bill
4. a means by which a third-party payer can verify that services billed were actually provided
5. and a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I understand and have read a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that Dr. Riddell reserves the right to change its notice and practices. I understand that I may obtain a copy of the revised Notice of Privacy Practices by calling Dr. Riddell's office and one will be provided to me. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations and that Dr. Riddell is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that Dr. Riddell has already taken action in reliance thereon.

_____ _____
Signature of Patient or Guardian Date

_____
Print Patient's Name

_____ _____
Print Guardian's Name Relationship to Patient