Dr Dunham Integrative Family Health NP, PLLC

Consent to Treat and Consent to Obtain Prescription Information

Consent to Treatment

I voluntarily authorize the rendering of such care, including diagnostic procedures and medical treatment, by authorized agents and employees of Dr Dunham Integrative Family Health NP, PLLC its nurse practitioners and their designees, as many in their professional judgement be deemed necessary or beneficial. I acknowledge that no guarantees have been made as to the effect of such examinations or treatments on my condition or the condition of the persons whom I am duly authorized to sign. I understand that I have the right to make decisions concerning my health care or the healthcare of the person for whom I am duly authorized to make such decisions, including the right to refuse medical and surgical procedures. This consent may be revoked in writing at anytime by the patient or duly authorized agent.

Consent to Obtain Prescription Information

I give Dr Dunham Integrative Family Health NP, PLLC permission to access prescription medication information from all sources, such as pharmacies, insurance companies, and prescription monitoring databases.

Certification

I certify that I have read and that I understand the consent to treatment and consent to obtain prescription information given above and I accept their terms.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_