Primary Physician Partners

Partners in Internal Medicine

Worcester Gastroenterology

Dimitrios Angelis M.D.

Consent for Medical Treatment

I knowingly and voluntarily consent to medical care, encompassing any evaluation, routine diagnostic procedures, and/or treatment by the attending physician, his/her assistance and/or other designees as deemed necessary.

Consent for Release of Information

During and after treatment the office may be required to release information to your insurance company, in order to obtain eligibility information of authorization for treatment. The office may also release information of copies of your health records to a licensed heath care facilities and/or agencies that may be involved in your current care of the continuation of care following each visit. The office may also receive requests to review your medical record by the payer after treatment. I consent to the disclosure and release of information as described above. The office will comply with Federal and State regulations for the protection of patient privacy and confidentiality.

Assignment of Benefits

I authorize direct payment to the office for any medical benefits otherwise payable for services rendered to my dependents of myself. **I am aware that it is my obligation to know my insurance company's policies and I am responsible for payment if I have not fulfilled their requirements.**

I have read and understand the information provided on this form.

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Signature of Patient/Parent/Guardian Date