CONFIDENTIALITY

We understand that your privacy is important. Your personal information would be used by the doctors and the clinic supportive personnel only for the purposes for providing medical treatment to you. Your medical records, including any results of testing would be kept exclusively at our office and will always meet HIPPA compliance and regulations. Only Dr. Ruterbusch, along with any medical research personnel would have access to your records. Your medical records will be kept for a period of 7 years.

No information about you or provided by you during the treatment would be disclosed to others without your written permission except if necessary to protect your rights or welfare, for example, (if you have a complication/injury or need emergency care) or if required by law.

Every effort will be made to ensure that your treatment and all records about you or your treatment will remain confidential. However, confidentiality cannot be absolutely guaranteed, for example, if a regulatory agency has the right to review the records from this treatment.

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

I have read (or somebody has read to me) the information provided above. I have been given an opportunity to ask questions and all of my questions have been answered to my satisfaction. I have been given a copy of this form for my records.

BY SIGNING THIS FORM, I WILLINGLY AGREE TO RECEIVE THE TREATMENT IT DESCRIBES.

_____

Name of Patient

_____

Name of Legal Representative and Description of Relationship (if applicable)

_____ _____

Signature of Patient or Legal Representative Date

SIGNATURE OF PHYSICIAN

I have explained the treatment to the patient of his/her legal representative and answered all of her/his questions. I believe that he/she understands the information described in this document and freely consents to receive this treatment.

_____

Physician Signature

Date_____