

PEUS, BIRCH, KAHMANN, GALLIVAN & ROMERO

A Medical Corporation
2324 Bath Street
Santa Barbara, California 93105
Telephone (805) 682-7801
Fax (805) 687-5342

CONSENT FOR TREATMENT. I voluntarily consent to care, treatment, testing and all other services performed by health care providers at Drs. Peus, Birch, Kahmann, Gallivan and Romero. However, I understand that I have the right to refuse to consent to ANY proposed treatment, surgery, procedure, or testing and I have the right to further discuss my concerns with my health care provider.

I understand that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may cause injury or even death. I acknowledge that no guarantees have been made to me as to the result of the examination or treatment.

I understand that I can revoke this consent at any time in writing except to the extent that the office of Drs. Peus, Birch, Kahmann, Gallivan and Romero, has acted in reliance upon this authorization and that I do not have to sign this authorization in order to receive treatment from Drs. Peus, Birch, Kahmann, Gallivan and Romero 2324 Bath Street, Santa Barbara, California 93105.

RELEASE OF MEDICAL INFORMATION: I understand that Drs. Peus, Birch, Kahmann, Gallivan and Romero shall maintain a record of medical care that I receive. This medical record will typically include information about my symptoms, results of physical examinations and diagnostic tests and plan regarding future care and treatment. This information is considered "protected health information" and, as such, will only be used or disclosed for the purpose of treatment, payment and healthcare operations and otherwise will not be released without my specific consent except as required by law.

I am aware, however, that information concerning my medical treatment and services rendered on my behalf may be released as necessary, to health care providers in emergent situations or to receive payment by public and private health insurance plans as outlined in Drs. Peus, Birch, Kahmann, Gallivan and Romero's financial policy: _____(initial)

PATIENT RIGHTS AND RESPONSIBILITIES: I understand that the office of Drs. Peus, Birch, Kahmann, Gallivan and Romero assume no responsibility for the use or misuse by others of my health information disclosed under this authorization. I release the office of Drs. Peus, Birch, Kahmann, Gallivan and Romero, its agents, and employees from all legal liability that may arise from this authorization. _____(initial)

ADVANCE DIRECTIVES: Adults 18 and older have the right to give directions about the future medical care or to designate another person(s) to make medical decisions if the individual loses decision making capacity. _____(initial)

I have read and understand this form and all of my questions have been answered to my satisfaction.

PATIENT NAME: _____ DATE: _____
(Print)

SIGNATURE: _____

PARENT/GUARDIAN OR CONSERVATOR: _____
(Sign)

