2019

PRIVACY POLICY, FINANCIAL RESPONSIBILITY AND CONSENT FOR TREATMENT

I, _____, hereby authorize Primary Care Physicians of Gainesville to administer examinations, immunizations, treatments, and view my prescription history from an external source as deemed medically necessary in the exercise of their professional judgement. Additionally, by signing this form I acknowledge that I have received a copy of the Privacy Policies and Financial Responsibility Policy for Primary Care Physicians of Gainesville.

_____ _____

Printed Patient Name Date of Birth

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

_____

Patient's Chart Number