# Authorization, Acknowledgement and Consent Summary

These authorizations/acknowledgements cover all services rendered to me, or the patient I am signing for, today and all future dates of service. I understand I may revoke this authorization by informing NextCare in writing, but if I do revoke this authorization, it will not affect anything prior to the date the revocation is received by NextCare.

**INFORMATION CHECKLIST**

| | | |
|---|---|---|
| I have received and read the Authorization to Treat and Bill | ____YES | ____NO |
| I have received and read the Notice of Privacy Practices | ____YES | ____NO |
| I have received and read the Patient Rights and Responsibilities | ____YES | ____NO |
| I have received and read the Consent for Email and Voicemail Communication | ____YES | ____NO |

**AUTHORIZATION OF INFORMATION RELEASE**

I have received a copy of NextCare's Notice of Privacy Practices. I authorize NextCare to release any information regarding my treatment; including lab results, x-rays, and medical records, to the following individuals/entities (NextCare may not release information or records to the names individuals/entities unless you identify them here):

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

NextCare will use my home phone number and primary address supplied during registration to contact me regarding my treatment; including lab results, x-rays, and medical records. I will ensure this information is up to date at every visit.

**COMMUNICATIONS CONSENT**

I have received a copy of NextCare's Consent for Communications and consent to all communication, including but not limited to lab test results, x-ray findings, medical records, future appointments, and other communication about my medical condition and advice from NextCare by the following means (check all that you consent to):

Email ____YES ____NO Email Address_____

Voicemail ____YES ____NO Phone Number_____

**PATIENT INFORMATION**

Patient Name (Printed) _____ Date of Birth: _____

Patient Signature: _____ Date: _____

Parent Representative (Printed)*: _____ Date*: _____

Parent Representative Signature*:_____ Relationship*: _____

*(Required if the patient is a minor or if the patient is unable to sign this form.)