MP VEERA MD PA 864 224 8689
CONSENT FOR MEDICAL TREATMENT:

PATIENT NAME_____DOB:_____

I HEREBY AUTHORIZE MP VEERA MD PA TO PROVIDE SERVICES TO ME/MY CHILD/MY RELATIVE (CIRCLE ONE) AND PERFORM ANY EXAMINATIONS, EVALUATIONS, TREATEMENTS, DIAGNOSTIC TESTS OR PROCEDURES WHICH, IN THE PHYSICIAN'S JUDGEMENT, MAY BE ADVISABLE.

I VOLUNTARILY CONSENT FOR MEDICAL TREATMENT AS NOTED ABOVE THAT IS BEING PROVIDED BY MP VEERA MD PA'S PROVIDERS AND STAFF. I AUTHORIZE THE PHYSICIAN TO RETAIN THE SERVICES OF OTHER PROFESSIONALS OR HEALTH PROVIDERS WHOSE SERVICES ARE CONSIDERED NECESSARY AND TO RELEASE RECORDS PERTAINING TO MY TREATMENT TO SUCH MEDICAL INSTITUTIONS/PROVIDERS.

I UNDERSTAND THAT IMPORTANCE OF MY PARTICIPATION IN MY OR MY CHILD'S/RELATIVE'S TREATMENT. I AGREE TO ABIDE BY THE MEDICAL PLAN PREPARED BY MP VEERA MD PA AND NOT MAKE ANY CHANGES IN THE MEDICAL PLAN WITHOUT FIRST CONSULTING WITH MP VEERA MD PA'S MEDICAL PROVIDER. I AGREE TO MAINTAIN THOSE RECORDS REQUESTED BY THE MEDICAL PROVIDER AND TO COMMUNICATE ANY CONCERNS ABOUT THE TREATMENT OR SIDE EFFECTS TO MP VEERA MD PA AS SOON AS POSSIBLE.

I AM AWARE THAT THE PRACTICE OF MEDICINE AND SURGERY IS NOT AN EXACT SCIENCE AND I ACKNOWLEDGE THAT NO GUARANTEES ARE TO BE MADE AS TO THE COURSE, DURATION OR RESULTS OF THE TREATMENT PLAN.

I GIVE THIS CONSENT VOLUNTARILY ON MY BEHALF OR ON BEHALF OF MY CHILD/RELATIVE, FOR WHOM I AM THE LEGAL REPRESENTATIVE.

PATIENT SIGNATURE_____ _____DATE: _____

OR

AUTHORIZED REPRESENTATIVE NAME: _____RELATIONSHIP:_____

AUTHORIZED REPRESENTATIVE SIGNATURE: _____DATE:_____

CONSENT FOR SHARING OF CLINICAL DATA AMONG PROVIDERS FOR YOUR CARE THROUGH HEALTH INFORMATION EXCHANGES (HIE)

I UNDERSTAND THAT DUE TO GOVERNMENT REGULATIONS MP VEERA MD PA IS USING SURESCRIPTS, A GOVERNMENT CERTIFIED HIE. AN HIE IS A SIMPLE AND SECURE ELECTRONIC NETWORK TO EXCHANGE MY CLINICAL DATA AMONG OTHER MEDICAL PROVIDERS AND PRESCRIPTIONS AMONG PHARMACIES AND PROVIDERS OVER THE INTERNET IN AN ENCRYPTED/SAFE AND SECURE MANNER. THIS SERVICE ENABLES MEDICAL PROVIDERS TO IMPROVE MY OVERALL MEDICAL CARE AND TREATMENT COORDINATION.

PATIENT SIGNATURE: _____DATE:_____

OR AUTHORIZED REPRESENTATIVE NAME: _____RELATIONSHIP:_____

AUTHORIZED REPRESENTATIVE SIGNATURE: _____DATE:_____