**Advance Preventive Medicine & Urgent Care**

Consent for Procedure/Treatment AND HIPAA PRIVACY

Email to **apmucor@gmail.com**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth----------- address-------------------------------------phone-------------

I hereby authorize and direct Dr. Shemiranei and assistants, as necessary to perform quality care, to perform the following procedure/treatment(s) on me:

Covid-19 Rapid Test Results are not guaranteed, you may receive a false positive or negative result. In general, antibodies can be detected 1-3 weeks after infection, as there is a window period. If any symptoms i.e. fever or cold appears, whether you received a positive or negative result, be sure to get further diagnosis combined with clinical indications and other diagnostic methods to prevent delay of treatment. Dr. Shemiranei is not and can not be held reliable for **ANY** test results you receive.

The nature and purpose of the procedure/treatment, alternative methods of treatment, and potential risks and complications have been fully explained to me, including but not limited to:

I acknowledge that no guarantees have been made to me as to the outcome of the procedure(s) and/or treatment(s).

I grant this consent without duress, confusion, or pressure from my physician and/or staff, associate, or colleagues.

\*\*\***FOR MM PATIENTS**: Dr. Shemiranei does not recommend Inhalation Route(Vaping) nor Smoking Route for Medical Cannabis unless you do not want to try any other routes. If you are a MM patient, by signing below you consent to use the smokable or vaping version which is not recommended by the provider.\*\*\*

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ hereby authorize ADVANCE PREVENTIVE MEDICINE & URGENT CARE and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment, and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve claims and health benefit coverage issues.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.Also I am responsible financially for all services at APMUCOR.

I understand that I have a right to revoke this authorization by providing written notice to. However, this authorization may not be revoked if, it’s employees or agents have taken action on this authorization prior to receiving my written notice. I also understand that I have aright to have a copy of this authorization.

I have been advised of this practice’s Privacy Practices, Release of Billing Information policy, Assignment of Benefits policy, and grant the practice Medication History Authority.

If applicable, Legal Representatives sign below:

By signing this form, I represent that I am the legal representative of the Member identified above and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Member’s behalf with respect to this authorization form.

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Patient Printed Name and signature witness signature----------------------- Date---------------------------