



CONSENT & AUTHORIZATIONS

Consent to Obtain Medical Records:

I hereby authorize Optimum Health to obtain medical records from any other physician or medical facility necessary in the course of my treatment.

Consent to Release Medical Information and/or Records:

I hereby authorize Optimum Health to release my medical records to other physicians or medical facilities necessary in the course of my treatment. I now hold harmless other physicians or medical facilities from any and all claims resulting from this release.

Pregnancy Disclaimer (for females only):

X-Rays are *not* performed on patients during pregnancy due to the health risks to the unborn fetus. Also, massage therapy is not recommended during the first trimester due to potential risk for miscarriage. I certify that I have been informed of these risks.

Authorizations:

I give permission to Optimum Health to use my address, email address, and phone numbers to contact me with appointment reminders, missed appointment notifications, birthday cards, holiday related cards, information about treatment alternatives, newsletters, discounts/specials, testimonials, or other health related information.

Nutrition Disclaimer:

I understand that the Optimum Health nutritional program or supplement suggestions made to me by the wellness coach are for educational purposes only. Supplements are not intended to diagnose, treat, cure, or prevent any disease, and have not been evaluated by the FDA.

Consent for Treatment:

I have had the opportunity to have any questions answered to my satisfaction. I have fully evaluated the risks and benefits of undergoing treatment in this office. I have freely decided to undergo the recommended treatment, and hereby give my full consent to treatment. In the case of an un-emancipated minor, the consent below is being given on his/her behalf.

Acknowledgment of Privacy Rights:

I acknowledge that Optimum Health has made available to me the *Notice of Privacy Practices and Individual Rights*. I acknowledge that I have read the above, am giving my consent to the above, and am acknowledging that I have been informed of my rights to privacy.

Patient Name (printed)

Patient Signature

Date

Witness Name (printed)

Witness Signature

Date