Consent for Medical Treatment

MEDICAL AND SURGICAL CONSENT FOR TREATMENT: The undersigned is under the care of his/her attending physician(s) and hereby consents to and authorizes the Pediatric Gastroenterology Associates/Dr. Muhammad A. Qureshi, MD to provide the necessary medical treatments(Including Emergency Department Services), surgical procedures, anesthesia, x-ray, examinations or treatments, laboratory procedures, drugs, and supplies to the patient. I acknowledge that no guarantee or assurance has been made as to the results of medical treatments, surgeries, or examinations. For the purpose of advanced medical knowledge, I consent to the presence of medical student and other health care trainees. I understand they may participate in my care under direct supervision of my attending physicians.

CONSENT TO ACCESS, REVIEW AND RETAIN PRESCRIPTION MEDICATION INFORMATION: I consent to and authorize Pediatric Gastroenterology Associates/Dr. Muhammad A. Qureshi, MD to access and review any of my electronic prescription medication history information which may be available to him, including but not limited to, prescriptions ordered and/or filled for me at any pharmacy. I understand that this historical prescription information will then become a permanent part of my electronic Medical record at Pediatric gastroenterology Associates.

PATIENTS RIGHTS AND RESPONSIBILITIES: I acknowledge that Pediatric Gastroenterology Associates /Dr. Muhammad A. Qureshi, MD have provided me with written information on my rights and responsibilities as a patient.

HOSPITAL MEDICAL RECORD RELEASE OF INFORMATION: I acknowledge that the Pediatric Gastroenterology Associates/Dr. Muhammad A. Qureshi, MD Privacy Notice has been made available to me. I understand that Pediatric Gastroenterology Associates/Dr. Muhammad A. Qureshi, MD may disclose information about me and the treatment I am receiving for purposes of continuous treatment, payment, and health care operations. I agree to hold harmless Pediatric Gastroenterology Associates/Dr. Muhammad A. Qureshi, MD, Its officers, directors, and employees and agents, from any and all liability, loss, claims, or damages relative to the release of such information.

ASSIGNMENT OF BENEFITS: I assign and authorize payment directly to Pediatric Gastroenterology Associates/Dr. Muhammad A. Qureshi, MD. I authorize any holder of Medical or other information about me to release to my insurance carrier and its agents any information needed to determine these benefits or benefits for related services.

I, the undersigned, certify that I have read and understand, and agree to the provisions contained within the consent form. The issues addressed on this form have been fully explained to me. I have had the opportunity to ask questions, and all of my questions have been answered to my satisfaction.

_____ _____

(Patient's Signature or signature of consenting on behalf of patient) (Date)