THE RIZZI GROUP
EXPERIENCE THE RIZZI DIFFERENCE

Patient Name: _____ DOB: _____

Consent for treatment please check <u>one or both</u>: ☐ Primary Care ☐ Mental Health

Person responsible for bills/statements if other than Patient: _____

Address:_____

Phone Number: _____ Relationship: _____

AUTHORIZATION AND CONSENT FOR MEDICAL TREATMENT

I, or my Legal Guardian undersigned, hereby consent to **The Rizzi Group**, for medical treatment including history, physical exam, diagnosis, plan and treatment for health-related problems, including the use of telehealth.

Assignment of Insurance Benefits:
The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or my dependent. I further expressly agree and acknowledge that my signature on this document authorizes **The Rizzi Group** to submit claims for benefits, for services rendered, or for services to be rendered, without obtaining my signature on every claim to be submitted for myself and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

Release of Information:
I, or my Legal Guardian undersigned, authorize the release of health information/medical records, including history, physical, discharge summaries, progress notes, radiology, lab and diagnostic reports, and all other pertinent medical records specified and maintained by the physician, clinic, hospital, or other related entity. Under the HIPAA (Health Insurance Portability and Accountability Act), I or my legal guardian understand that I have specific rights about the privacy of my health information. Hereby, I acknowledge that I have been informed about the possible use and disclosure of protected health information. I may revoke my consent in writing except to the extent that the practice has already made disclosures based on my prior consent. If I do not sign this consent, or later revoke it, **The Rizzi Group** may decline to provide treatment to me.

_____ _____
Signature of Patient or POA Date

Verbal consent given by: _____ Relationship to Patient: _____
(name of POA/Next of Kin giving consent)

Signature of Provider/Person filling out the form if **NOT** Patient: _____