Gateway Medical

# Consent for Treatment

*Please provide your initials next to each section below:*

_____ I hereby authorize and grant permission for the providers of Gateway Medical, and their staff, to provide reasonable and necessary medical treatment.

_____ I hereby authorize and grant permission for Gateway Medical to release my medical information to any referring provider, hospital, post-acute care provider and/or medical facility involved with my care. My consent to release this information from my medical records shall continue until I expressly revoke this consent in writing.

_____ I hereby authorize and grant permission for Gateway Medical to release my medical information to my insurance carrier(s) for the purpose of treatment and health care services provided to me.

_____ I hereby authorize and grant permission for Gateway to release my medical information to my insurance carrier(s) for payment and billing purposes.

_____ I hereby authorize and grant permission for Gateway Medical to bill my insurance carrier(s) for payment of health care services provided to me. I understand that I am responsible for any amount that is not covered by my insurance carrier(s).

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Date

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