Medical Pavilion Clinic

2525 Harbor Blvd. Port Charlotte, Fl. 33952
(941) 629-9190

1. **CONSENT FOR MEDICAL TREATMENT**:
   The undersigned hereby consents any medical treatment or services rendered the patient by the physician or staff. I also acknowledge that no guarantee or warranty has been made by the physician or staff as to the results of any treatment, which may be given or performed.

2. **AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION**:
   Medical Pavilion Clinic is hereby authorized to disclose all or any part of the medical record of myself and/or the patient named on this consent to the patient's insurance.

THIS AUTHORIZATION IS GIVEN WITH THE FULL KNOWLEDGE THAT SUCH DISCLOSURE MAY CONTAIN INFORMATION WHICH MAY RESULT IN A DENIAL OF INSURANCE BENEFITS OR WHICH MAY BE OTHERWISE HARMFUL TO ME AND/OR THE PATIENT.

3. **FINANCIAL AGREEMENT:**
   THE INDERSIGNED AGREES, WHETHER SIGNING AS Representative or as Patient is hereby obligated to pay the account. In the event that this account goes to suit to enforce payment of this account, I agree to pay such additional sums as collection fees and attorney fees as the court may judge reasonable.

   I also release the Medical Pavilion Clinic and its employees from all liability which may arise as a result of such treatment, unless due to the sole negligence of the physician and/or staff.

Patient or legal guardian: ______________________________

Date: ______________________________

Witness: ______________________________

REASON PATIENT UNABLE TO SIGN: