



PATIENT CONSENT FOR TREATMENT:

I hereby give my consent for evaluation, testing and treatment as directed by Alpha Primary Healthcare.

Patient Signature: _____ Date _____

Patient Name: _____

Parents/Guardian Signature: _____ Date _____

Parents/Guardian Name: _____

Patient Consent for Release of Protected Health Information (PHI)

I, _____, give my consent to Alpha Primary Healthcare to release protected health information (PHI), such as; lab results, medication changes, appointments, billing information, etc., to the following individuals:

This will expire only with written notification from me.

Signature _____

Print Name _____

Date: _____