Statement of Informed Consent, Consent to Contact, and Release of Medical Information

I ____ DOB ___________________
thoughtfully and purposefully allow and encourage Dr. Alan F. Bain, D.O., at his discretion and in compliance with Meaningful Use Attestation and Privacy Rule as set forth by Health Insurance Portability and Accountability Act (1996) under Non-Research Based Information Gathering, to contact directly by all secured means available, all medical personnel, both current and former, that treat, or have treated, me for any medical reason in an attempt to best coordinate and further his understanding of my healthcare goals and parameters.

I am currently utilizing other medical providers and I understand that for Dr. Alan F. Bain, D.O., to make informed medical decisions concerning my care, he must have complete and uncensored access of my medical history and to those individuals that provided me with service.

I understand that in order for Dr. Alan F. Bain, D.O., to treat and or confer with me about my future/present/former healthcare, he must have unfettered access to my current/former medical records and by my signature below I am authorizing complete access.

I hereby acknowledge and grant Informed Consent, Consent to Contact and Release of My Medical Information, to Dr. Alan F. Bain, D.O., in accordance with generally accepted and prudent medical practices. I will provide Dr. Alan F. Bain, D.O., with names and numbers of all of my current medical providers and, if possible, the names and numbers and or locations of former medical providers, so that he may contact them and discuss their medical findings.

This personally signed consent, or its facsimile, also allows medical providers that have provided me with medical services to disclose documents and talk with Dr. Alan F. Bain, D.O., about their clinical observations and treatment results.

I understand that my records will be kept strictly confidential and that I can discuss with Dr. Alan F. Bain D.O., his findings and request copies of all medical documentation. It is my responsibility to report to Dr. Alan F. Bain D.O., any and all physical concerns I may incur as soon as possible and any changes in my treatment protocol or medication regiment by other medical practitioners.

_______________________________________ _______________________

Releasor Printed Name Date

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Releasor Signature

_______________________________________ _______________________

Dr. Alan F. Bain, D.O. Date

Name of previous or present GP or Internist | Phone

OB/GYN | Phone

Specialist | Phone

Specialist | Phone

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