CONFIDENTIAL MEDICAL REPORT

David A. Frenz, M.D.
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Patient Name
Date of Birth

General Consent Form

1. Consent for Treatment

I consent to Dr. Frenz, his staff and his designees to examine, treat, complete tests, complete routine procedures and to prescribe medications considered necessary or advisable.

2. Release of Medical Records

I agree that information from my medical record may be used by or given to referring providers, their staff, and/or Dr. Frenz's business associates as necessary for treatment and the operation of Dr. Frenz's medical practice, so long as any release of information is in compliance with the law.

3. Release of Medical Records for Medical or Scientific Research

Medical records, regardless of when generated, may be released for the purpose of medical or scientific research unless a written objection is completed. This release may be revoked by me in writing at any time.

4. Payment and Insurance Consent

I authorize Dr. Frenz to release information about me to any insurance company/payor responsible for paying for my health care. I further agree to the release of information to any payor or external vendor chosen by a payor to meet authorized utilization review and quality reporting requirements.

5. Notice of Privacy Practices

I acknowledge that Dr. Frenz provided me with a printed (paper) copy of his Notice of Privacy Practices.

6. Consent to Disclose Information

The following consent is on the behalf of third party payors. I authorize my insurance company or health plan administrator to share my records with Dr. Frenz about services that I have received from hospitals, clinics, physicians and other health care providers that are unrelated to Dr. Frenz. These records allow my insurance company or health plan administrator to better coordinate my care and to improve the quality of the care that I receive.

By signing below, I consent to all of the above and I acknowledge that I have received a printed copy of Dr. Frenz's Notice of Privacy Practices.

Your Signature & Today's Date: _____

If patient's representative, under what legal authority are you signing?

☐ Parent ☐ Guardian ☐ Health Care Agent ☐ Other: _____