

Central Coast Lymphedema Therapy
1061 Murray Ave., San Luis Obispo, CA 93405
(805) 782-9300 – Fax (805) 782-9700
Email – cclymph@hotmail.com

Patient Name: _____

CONSENT TO TREAT

____ I, the undersigned, hereby consent to and authorize the administration of all treatment and therapies that may be considered advisable and/or necessary in the judgment of my therapist.

This authorization shall remain in full force and effect for this and future outpatient visits.

RELEASE OF RECORDS

____ I hereby authorize Central Coast Lymphedema Therapy to release any and all information contained in my medical record to the referring physician.

____ I hereby authorize Central Coast Lymphedema Therapy to release any and all information contained in my medical record to insurance companies or any other agencies to which claim is made for coverage.

PHOTO RELEASE

____ I hereby authorize Central Coast Lymphedema Therapy to take photographs of appropriate parts of my body to provide supporting documentation of my medical condition. I understand that any photographs taken will be placed in and remain part of my medical record.

____ I hereby authorize Central Coast Lymphedema Therapy to use photographs of me, without identifying me, for educational and/or publicity purposes.

Signature of Consenting Patient/Guardian

Date

Witness

Date