



Patient Demographics:

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender: M / F / Transgender / Non-Binary / Other  
Address: \_\_\_\_\_  
Phone: \_\_\_\_\_ Email: \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Relation: \_\_\_\_\_

**Emergency Contact:**

Name: \_\_\_\_\_  
Phone: \_\_\_\_\_  
Relation: \_\_\_\_\_

Assignment and Release:

I hereby authorize and direct payment of my insurance benefits for myself or my dependents (otherwise payable to me) to **South Lyon Family Docs**. I understand that I am financially responsible to the medical group for charges not covered by this authorization. I authorize South Lyon Family Docs to use and disclose my protected health information as necessary to contact my insurance company for obtaining payment, authorization, and determination of insurance benefits payable for related services.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Release of Patient Information:

I give permission to **South Lyon Family Docs** to share my health information, including medical and billing records, with the person(s) listed below for care, payment, or other stated purposes. I may cancel this permission in writing at any time, unless the information has already been shared. I understand that once shared, the information may no longer be protected by federal privacy laws. This permission will end one (1) year from the date I sign this form unless I choose a shorter time.

**YES** \_\_\_ **NO** \_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Signer: \_\_\_\_\_



## General Consent For Treatment

**Consent for Treatment:** I voluntarily consent to medical or surgical treatment, diagnostic testing, and treatment by the providers and clinical staff of **South Lyon Family Docs**. This may include examinations, laboratory testing, HIV and Hepatitis B/C testing, immunizations, medications, surgical in-office procedures, and telehealth services when appropriate. I understand that I may ask questions and refuse treatment to the extent permitted by law.

**Release of Information & HIPAA:** I authorize the use and disclosure of my health information for treatment, payment, healthcare operations, insurance claims, and as otherwise required by law (including public health reporting). A copy of our HIPAA agreement is available.

**HIV and Hepatitis Testing:** I understand that testing for Human Immunodeficiency Virus (HIV) and Hepatitis B and C may be performed when medically appropriate or requested. I understand that positive test results may be reportable to public health authorities as required by Michigan law. I acknowledge that I may receive counseling or additional information regarding such testing if requested.

**Testing, Use, and Disposal of Specimens and Tissues:** I consent to the collection of blood, urine, tissue, or other specimens for diagnostic and treatment purposes. I authorize the practice and/or its designated laboratory to test such specimens as medically necessary. I understand that specimens and tissues may be disposed of in accordance with standard medical practice and applicable laws once testing and medical requirements have been completed.

**Valuables:** I understand that the practice is not responsible for loss or damage to personal belongings or valuables brought to the office.

**No Guarantees:** I acknowledge that the practice of medicine is not an exact science and that no guarantees or assurances have been made regarding the results of my treatment.

**Consent for Treatment of Minor (if applicable):** I certify that I am the parent or legal guardian of the above-named minor and have legal authority under Michigan law to consent to medical treatment on their behalf.

I certify that I have read and understand this consent form and agree to treatment.

**Patient Name:** \_\_\_\_\_ **Patient DOB:** \_\_\_\_\_

**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I \_\_\_\_\_, hereby authorize

Person/Organization to Release Information \_\_\_\_\_

Address \_\_\_\_\_

Phone/Fax Number \_\_\_\_\_

to release information contained in my patient medical record INCLUDING alcohol and drug abuse records protected under the regulations of 42 Code of Federal Regulations, Part 2, if any, psychiatric, psychological service records, if any, and social work records. If any, including communications made by me to a social workers psychiatrist/psychologist, and any information regarding communicable diseases and serious communicable diseases and infections as defined by Michigan Department of Public Health rule which can include venereal disease, tuberculosis, HIV, AIDS or ARC, if any, to individuals or organizations listed below under the conditions listed below:

1. Person to Whom Disclosure is to be made:

**SOUTH LYON FAMILY DOCS**

Address: **26006 Pontiac Trail, South Lyon MI 48178**

Fax Number: **248-437-5694**

2. DO NOT DISCLOSE THE FOLLOWING (Check all that apply)  Alcohol and/or Drug Abuse Information  
 HIV, AIDS, or ARC Information  Psychiatric Information

3. \_\_\_\_\_  
SPECIFIC AND MEANINGFUL DESCRIPTION OF THE INFORMATION TO BE DISCLOSED – INCLUDE DATES

4. The purpose and need for such disclosure:  CONTINUATION OF TREATMENT/FOLLOW-UP  
 BILLING INFORMATION/INSURANCE  PER THE REQUEST OF THE INDIVIDUAL  
 OTHER (specify) \_\_\_\_\_

You have the right to revoke this authorization at any time. If you revoke your authorization, the information described above may no longer be used or disclosed. The request to revoke must be in writing and must be received prior to release of information. Unless otherwise revoked, this authorization will expire six (6) months from the date of signing.

I understand that my health information that is disclosed under this Authorization may be subject to redisclosure by the recipient and the privacy of my health information will no longer be protected by the law.

Signature(s): \_\_\_\_\_ Date: \_\_\_\_\_  
Patient

\_\_\_\_\_  
Driver's License Number Date of Birth of Patient Last four digits of SSN

\_\_\_\_\_  
Parent/Guardian /Legal Representative Date: \_\_\_\_\_

\_\_\_\_\_  
Driver's License Number

Legal Representative Paperwork:  Proof of Guardianship  Durable Power of Attorney for Healthcare  
(attach a copy)  Letters of Authority

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_