



PATIENT CONSENT & AUTHORIZATION STATEMENT

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I, _____, hereby grant permission for any and all medical attention to be administered to me in the event of accident, injury, sickness, etc. I understand that I have the right to refuse any such treatment. I also assume the responsibility for the payment of any such treatment, and give Solvera Health permission to submit claims to insurances on my behalf.

This release is effective for the period of one year from the date given below.

Solvera Health is specifically authorized to release all health care information pertaining to diagnosis, testing or treatment.

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PATIENT SIGNATURE

DATE

PARENT / LEGAL GUARDIAN SIGNATURE

RELATIONSHIP TO
PATIENT