DR. KEEL & ASSOCIATES HEALTHCARE CLINIC

Urgent Care ~ Family Health ~ Occupational Medicine

I hereby give consent to be treated by Dr. Edwin A. Keel, or any covering physician at Dr. Keel & Associates Healthcare Clinic. If the patient is a MINOR: I hereby give consent for _____ to be treated by Dr. Edwin A. Keel, or any covering physician at Dr. Keel & Associates Healthcare Clinic. I further agree to pay all charges for treatment to patient. Medical records will not be released until account balance is paid in full. I understand that my failure to pay these charges can result in placement for outside collections. I further agree that I will be responsible for all cost of collections, including but not limited to collection fees, reasonable attorney's fees and court cost.

PRINT NAME _____ **SS#** _____ **DOB** _____

SIGNATURE _____ **DATE** _____

WITNESS _____ **DATE** _____

CONSENT FOR RELEASE OF MEDICAL INFORMATION

I hereby give consent for Dr. Keel & Associates Healthcare and/or Dr. Keel & Associates Healthcare After Hours Clinic to release my or my child's, _____ _____ , medical information to the following people:

Parents: _____

Grandparents: _____

Spouse: _____

Children: _____

Siblings: _____

Others: _____

No One: _____

_____ I authorize Dr. Keel & Associates Healthcare and/or Dr. Keel & Associates Healthcare After Hours Clinic to leave detailed messages concerning my or my child's medical treatment, laboratory and/or test results, medications or appointment information on my answering machine or with the above named person or people.

_____ I do not authorize Dr. Keel & Associates Healthcare and/or Dr. Keel & Associates Healthcare After Hours Clinic to leave detailed messages concerning my or my child's medical treatment, laboratory and/or test results, medications or appointment information on my answering machine.

Signature: _____

Date: _____