veriMED Health Group
Mariner

CONSENT TO CARE

I permit *veriMED Health Group – Mariner* and their respective employees and agents caring for me to treat me in ways they judge are beneficial to me. I understand that this care may include tests, examination, medical and surgical treatment and consultations with appropriate specialists. No guarantees have been made to me about the outcome of this care.

RELEASE OF INFORMATION

I agree to the release of information from my medical record for reimbursement for health care services provided, follow up evaluation, and/or patient specific benefits, to any of the following as necessary.

- Social Security Administration, or those operating on their behalf (includes Medicare and disability)
- Any insurance organization, compensation carrier or welfare agency providing financial assistance for services provided.
- Identified referring

I also agree to authorize *veriMED Health Group – Mariner* and their respective employees and agents to obtain information from my physician(s), transferring facility (ies), and rehabilitation centers for the purposes of follow up evaluation.

_____ Date: _____
(Patient/Guarantor signature)

_____ Date: _____
(Witness signature)

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