CT Integrated Pain Consultants
Zhaodi Gong, MD/PhD

Consent to Treatment & Release of Information

Please print this form, sign and bring it with you to your appointment.

Patient Name: _____ Date of Birth: _____

SSN: _____ Today's date _____ Time _____ am/pm

I, _____, voluntarily consent to outpatient care at CT Integrated Pain Consultants, LLC encompassing routine examination, medical treatments including, but not limited to, interventional pain procedures with administration of medication by the physician.

I further consent to the performance of these procedures, examination and rendering of the medical treatment by the medical staff and their assistants, including nurse practitioners, physician assistants, medical assistants, or their designees as is necessary in the medical staff's judgment.

Release of Information: I authorize CT Integrated Pain Consultants, LLC, to release medical information to the third party insurance carriers for the purpose of filing insurance claims related to my medical care.

I further authorize the release of medical information about treatment and progress here to my primary care physician, referring physician or anyone designated by me below:

(Name) _____

(Relationship) _____

(Phone number) _____

I understand that this consent form will be valid and remain in effect as long as I receive medical care at CT Integrated Pain Consultants, LLC.

This form has been explained to me. I fully understand and agree to its contents.

Patient Signature: _____

Date: _____

Witness: _____

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