



FORM 6

**PHILADELPHIA HEALTH ASSOCIATES
ADULT MEDICINE, P.C.**

www.phaadultmedicine.com

Shahana N. Karim, MD
Jon A. Shapiro, MD
Wilbert R. Warren, MD, FACP

1740 South Street, Suite 300
Philadelphia, PA 19146
Fax: 215-732-1812
TEL: 215-732-0876

Authorization for Routine Examination and Treatment

1. I voluntarily consent to routine diagnostic procedures and medical care as deemed necessary in the judgment of my Provider(s) (including physicians, physician assistants and nurse practitioners) and whom ever may be delegated assistants of any Provider(s).
2. I understand that this consent does not include operations or any non-routine procedures or treatment, and the risks and alternatives for such procedures or treatment which a reasonable patient would consider significant to a decision whether or not to undergo such treatment or procedures will be explained to me by my Provider(s) or another Provider(s) designated by him/her.
3. I realize that I have the right to refuse any drugs, treatment or procedure to the extent permitted by law.
4. I acknowledge that because medicine is not an exact science, no guarantees or warranties can be made to me regarding any results of any diagnostic procedures or medical treatment performed at Philadelphia Health Associates-Adult Medicine, PC.
5. I hereby authorize Philadelphia Health Associates-Adult Medicine PC to release to third party payers pertinent medical information relating to my medical care to the extent permitted by law.
6. With my signature below, I acknowledge that I understand the above and I any questions I may have had were answered to my satisfaction.

Patient Name

Signature

Date

Guardian/Representative

Signature

Date

Guardian/Representative relationship to patient