CONSENT TO RELEASE INFORMATION

PATIENT NAME: _____

_____ I GIVE CONSENT TO DR. A. MICHAEL MARASCO TO DISCUSS MY MEDICAL CARE AND MEDICAL INFORMATION WITH:

Name	Relationship
Name	Relationship

Signed (patient or parent if minor) _____ Date _____

CONSENT TO TREAT

I authorize and give consent to my physician (Dr. A. Michael Marasco) to provide and perform such medical/surgical care, diagnostic tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well being. I understand that no representatives, warranties or guarantees have been made as to the results of the care, treatment and/or medications given to me. This consent shall be in effect until I choose to revoke it in writing.

Signed (patient or parent if minor) _____ Date _____

AUTHORIZATION FOR APPOINTMENT NOTIFICATION

I authorize the staff of Dr. A. Michael Marasco to notify me of upcoming appointments by telephone, on my designated answering machine, message left with family member or by mail (postcard).

Signed (patient or parent (if minor) _____ Date _____