CONSENT TO TREATMENT FORM:

I.....

voluntarily consent to receive medical and health care services provided by Gilead Medical & Dental Center physicians, employees and such associates, assistants, and other health care providers (otherwise referred to as GMDC), as my physicians deem necessary. I understand that such services may include diagnostic procedures, examinations, and treatment.

I understand photographs, videotapes, digital and/or other images may be made/recorded for treatment and payment purposes only.

I acknowledge that no warranty or guarantee has been made to me as to result or cure.

I acknowledge that GMDC may use health information exchange systems to electronically transmit, receive and/or access my medical information which may include, but is not limited to, treatments, prescriptions, labs, medical and prescription history, and other health care information.

I understand that this Consent to Treatment/Health Care Agreement will be valid and remain in effect as long as I attend or receive services from the GMDC outpatient Clinics, unless revoked by me in writing with such written notice provided to each clinic I attend or from which I receive services.

SIGNATURE .....

DATE.....