The Rizzi Difference
RIZZI GERIATRIC ASSOCIATES

AUTHORIZATION AND CONSENT FOR TREATMENT

Name of Community:_____

Patient Name: _____ **DOB:** _____

Person responsible for bills/statements if other than patient: _____

Address: _____

Phone Number: _____ Relationship: _____

I, or my Legal Guardian undersigned, hereby consent to **RIZZI GERIATRIC ASSOCIATES**, for medical treatment including history, physical exam, diagnosis, and plan and treatment for health-related problems. **I understand that I have a choice of provider, and that I may refuse treatment or terminate health services at any time. I also give consent for telehealth/telemedicine and understand there is no additional fee for this service. I give consent for monthly collaborative consultations between psychiatry, primary care medicine, and the interdisciplinary team to monitor patient progress.**

Assignment of Insurance Benefits:
The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependent. I further expressly agree and acknowledge that my signature on this document authorizes **Rizzi Geriatric Associates** to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each and every claim to be submitted for myself and/or department and that I will be bound by this signature as though the undersigned had personally signed the particular claim.

Release of Information:
I, or my Legal Guardian undersigned, authorize the **release of health information/medical records** including history, physical, discharge summaries, progress notes, radiology, lab and diagnostic reports, and all other pertinent medical records specified and maintained by the physician, clinic, hospital, or other related entity. Under the HIPAA (Health Insurance Portability and Accountability Act), I or my legal guardian understand that I have specific rights pertaining to privacy of my health information. Hereby, I acknowledge that I have been informed about possible use and disclosure of protected health information. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Rizzi Geriatric Associates** may decline to provide treatment to me.

_____ _____
Signature of Patient or POA Date

Verbal consent given by: _____ Relationship to Patient _____

Date: _____

_____
Signature of person completing form if verbal consent is obtained for this patient

Disclosure: Rizzi Geriatrics Associates has an investment interest in Rizzi Mental Health Associates. Rizzi Mental Health Associates is located at 936 Barcarmil Way, Naples, FL 34110. (239) 265-3391. This disclosure is to reiterate that patients have the right to obtain services from a provider of their choice. The names and addresses of alternative clinicians are available to patients. 1. Rizzi Mental Health Associates, 2. Lee Behavioral Health Center, 12550 New Brittany Blvd, Suite 100, Ft. Myers, FL 33907 (239) 343-9180. 3. Dr. Jeffrey Fabacher, 700 2nd Avenue North, #302, Naples, FL 34102, (239) 261-8188. (2022).