Medical Release Form

Patient Information

Patient Name: _____

Date of Birth:_____ SSN:_____

Address: _____ City: _____

State:_____ Zip Code:_____ Phone: (____)____-_____

Email:_____

Information Requested From:

Name: _____

Address: _____ City: _____

State:_____ Zip Code:_____ Phone: (____)____-_____

Email:_____ Fax: (____)____-_____

Send Information To:

Send by: • Mail • Secure Email • Fax
Name: Olive Health
Address: 4812 W Trapnell Rd, Plant City, FL 33566
Phone: (813) 417-4767
Email: Frontdesk@olivehealthfl.com Fax: (888) 814-0945

I hereby grant permission for you to release confidential health information about me, by releasing a copy of medical record, or a summary or narrative of my protected health information to Olive Health for _____ (Patient Name).

Signers name: _____

Relationship to patient: _____
(Patient,Parent,Guardian POA, Health Care Surrogate)

Signature: _____ Date:_____

Consent to Treat Form

1. I give permission for **Olive Health, LLC** to give medical treatment to _____ (patient name).

2. I allow **Olive Health, LLC** to file for insurance benefits to pay for the care I receive. I understand that:
   - **Olive Health, LLC** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay or I do not have insurance.
3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

You have the right, as a patient, to be informed about your condition and the recommended surgical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing.

You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your healthcare provider, we encourage you to ask questions.

By affixing my signature below, I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signers name: _____

Relationship to patient: _____
(Patient,Parent,Guardian POA, Health Care Surrogate)

Signature: _____ Date:_____

Medication List (please list out your meds or use the upload link below)

	Name of med	Dosage	Frequency	Special intructions
Med1				
Med2				
Med3				
Med4				
Med5				
Med6				
Med7				
Med8				
Med9				
Med10				

CHRONIC CARE MANAGEMENT (CCM) SERVICES CONSENT FORM

Olive Health
813-417-4767
frontdesk@olivehealthfl.com

PATIENT INFORMATION

Patient Name: _____ **DOB:** _____

Address: _____

Phone: _____ **Emergency Contact:** _____

CONSENT FOR CHRONIC CARE MANAGEMENT SERVICES

I, _____, understand and consent to participate in Chronic Care Management (CCM) services provided by Olive Health.

WHAT IS CHRONIC CARE MANAGEMENT (CCM)?

Chronic Care Management is a Medicare and insurance-covered service designed to help patients with multiple chronic conditions receive coordinated, comprehensive care between office visits. CCM services include:

- **Care Coordination:** Regular communication between your healthcare team members
- **Medication Management:** Review and monitoring of your medications
- **Health Monitoring:** Regular check-ins about your symptoms and conditions
- **Care Plan Development:** Creating and updating a personalized care plan
- **24/7 Access:** Access to healthcare providers for urgent questions
- **Specialty Care Coordination:** Help managing referrals and specialist appointments

CCM SERVICES PROVIDED

I understand that CCM services may include:

✓ Monthly phone calls or secure messaging to discuss my health status
✓ Review of my medications and potential interactions
✓ Coordination with specialists and other healthcare providers
✓ Development and updates to my comprehensive care plan
✓ Health education and self-management support
✓ 24/7 access to clinical staff for urgent questions
✓ Electronic health record management and care coordination

BILLING AND INSURANCE

- CCM services are typically covered by Medicare and many insurance plans
- I understand there may be copays or deductibles associated with these services

- I authorize Olive Health to bill my insurance for CCM services
- I am responsible for any amounts not covered by insurance

COMMUNICATION PREFERENCES

I consent to be contacted via (check all that apply):

- ☐ Phone calls to: _____
- ☐ Text messages to: _____
- ☐ Secure patient portal messaging
- ☐ Email to: _____

PATIENT RIGHTS AND RESPONSIBILITIES

My Rights:

- I can refuse CCM services at any time without affecting other care
- I can revoke this consent at any time by contacting the practice
- I have the right to a copy of my care plan
- I can request changes to my communication preferences

My Responsibilities:

- Participate actively in my care management
- Keep scheduled appointments and respond to outreach attempts
- Inform the care team of changes in my condition
- Update contact information when it changes

PRIVACY AND CONFIDENTIALITY

I understand that:

- My health information will be protected according to HIPAA regulations
- Information may be shared among my care team members for coordination purposes
- Electronic communication carries some privacy risks, which have been explained to me

CONSENT AND SIGNATURES

I have read and understand this consent form. I have had the opportunity to ask questions about CCM services. I voluntarily consent to participate in Chronic Care Management services. I understand I can withdraw from CCM services at any time

Signature: _____ **Date:** _____

Signers Name (Print): _____