CONSENT TO TREATMENT

I, _____, authorize Elias Dagnew, M.D. / Viren Vasudeva, MD to perform medical treatment.

I authorize any physician, medical practitioner, hospital or other medical facility, peer review organization, insurance company, the Healthcare Financing Administration, the Medical Information Bureau, Inc., employer or third-party administrator having information available as to diagnosis, treatment and prognosis with respect to any physical or mental condition and/or treatment of me.

I understand the information obtained by **Georgia Brain & Spine Center** will be used to determine eligibility for insurance, and eligibility for benefits under my insurance coverage. Any information will not be released except to the persons or organizations performing business or legal services in connection with the claim, or as may be otherwise lawfully required or as I may further authorize.

I agree that this authorization shall be valid until rescinded in writing or replaced by one of a later date.

Please be advised that your medical history is strictly confidential. Absolutely NO information will be released without proper legal consent, unless deemed by laws of the state of Georgia.

_____ _____

Signature of Patient/Guardian Date