NWABUEZE
PRIMARY CARE CLINICS

EAST FELICIANA PRIMARY CARE CLINIC
3050 Charles Dr. Jackson Louisiana 70748
Ph (225) 634-3517

Nwabueze Internal Medicine and Primary Care
18289 Gould Dr St Francisville, LA 70775
Ph (225) 635-3072

Patient Name: _____ **Date**: _____

CONSENT FOR MEDICAL TREATMENT

I consent to and authorize Nwabueze Nnamdi Inc, East Feliciana Primary Care Clinic, and staff personnel to perform care and treatment including but not limited to medical treatment, laboratory, and/or diagnostic testing that may be ordered by said personnel.

I certify that I have read and understand the above authorization for medical treatment.

X_____
Signature of Patient (or Guardian)

ADVANCE DIRECTIVES

I have a Living Will ☐ Yes ☐ No
I have a Medical Power of Attorney ☐ Yes ☐ No

If Yes, I understand it is my responsibility to provide a copy for my medical records.

X_____
Signature of Patient (or Guardian)

ACCESS TO MEDICAL RECORDS

Our Clinic is able to provide you with a summary of what was discussed during your visit.
This information can be obtained in two ways:

1) by requesting a paper summary at the end of each visit or
2) by joining myHEALTHware.

myHEALTHware is an electronic service we are able to provide and by joining, you will have access to your medical records online any time, any place. This will allow you to share your records with other providers or healthcare organizations as well as be able to communicate with our office, all from a single account.

☐ I will request a paper summery if I desire to do so
☐ I would like to join myHEALTHware.
Send invite to join by: ☐ e-mail ☐ text message ☐ phone call

X_____
Signature of Patient (or Guardian)