

**Consent for Medical Treatment**  
**Dr Ricardo Estape and Dr Nicholas Lambrou**

1. I, the undersigned patient or \_\_\_\_\_ (name of authorized representative acting on behalf of patient) consent to undergo all necessary tests, medication, treatments, and other procedures in the course of the study, diagnosis, and treatment of my illness(es) by the medical staff and other agents and/or employees Ricardo Estape M.D., LLC . The identity of the physician who currently has primary responsibility for my care has been provided to me.
2. I understand that, absent emergency or extraordinary circumstances, non-routine and major medical procedures will not be performed upon me until I have had an opportunity to discuss and agree to them with a physician.
3. I am aware that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me as to the results of diagnosis, examinations or treatments in the hospitals or clinics.
4. I hereby authorize the staff of Ricardo Estape M.D., LLC, to take such still photographs, motion pictures, television transmission, and/or videotaped recording for educational and evidentiary purposes as they may wish.
5. I hereby grant access to medical records for bona fide research to members of the medical staff and other medical researchers and authorize my medical records and results to be used for research. I realize that my records will not be identified as pertaining to me specifically without my expressed permission.
6. I consent to the release of medical information to other institutions, agencies, health care organization, or health care providers accepting the patient for medical or institutional care, and consent to the release of medical information to patient's insurer and/or managed care organization and their agents for purposes including but not limited to Utilization Review and Quality Assurance Review.
7. I hereby authorize payment directly to Ricardo Estape M.D., LLC of benefits due to me in my pending claim and/or MAJOR MEDICAL BENEFITS otherwise payable to me, but not to exceed the Hospital and/or Physician's regular charges for this period of treatment. I agree that a photo static copy of this authorization is as valid as the original.

I have read and clearly understand the above.

\_\_\_\_\_  
Signature of patient or patient's authorized representative

Date: \_\_\_\_\_ Time: \_\_\_\_\_ AM/PM

\_\_\_\_\_  
Witness' Signature

\_\_\_\_\_  
Witness' Signature

**MINORS CONSENT:** Unemancipated patients (minors under 18 yrs of age) must have parents or guardians signature, except for emergency medical care, diagnosis or treatment of a sexually transmitted disease, or treatment of pregnancy.

\_\_\_\_\_  
Parent or Guardian's Signature

**EMERGENCY CONSENT:** Patient is unattended by legal guardian, health care surrogate, or relative and/or unable to sign consent for treatment necessary to correct or stabilize a serious medical condition(s) demanding immediate medical attention. I certify that this condition will endanger the life, limb or health of the patient and authorize emergency procedures.

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Time

AM/PM