

Apothikor LLC Patient Consent Form

Acknowledgment of Revocation

I acknowledge that I am of sound mental capacity and fully capable of reading and comprehending this Patient Consent Form. Nothing is currently preventing me from reading or understanding the terms of this Patient Consent Form.

I hereby authorize the providers at Apothikor Wellness to make recommendations regarding my healthcare and to communicate those recommendations to me and to my other healthcare providers. The providers at Apothikor Wellness have advised me of the possible health risks associated with their recommendations. I understand those risks and voluntarily choose to move forward with the implementation of Apothikor Wellness' recommendations.

As such, in light of my understanding of the possible health risks and decision to voluntarily move forward with the implementation of Apothikor Wellness' recommendations, I hereby waive, release, and hold harmless Apothikor Wellness LLC from any and all claims, injuries, or damages of any nature which arise in connection with Apothikor Wellness' recommendations, should they occur now or at any time in the future. I understand that I have the right to deny recommendations made to me or to revoke authorization of Apothikor Wellness LLC to make such recommendations to my healthcare providers by informing Apothikor LLC. If I do revoke this authorization in the future, I acknowledge and understand that such revocation will not revoke or rescind any actions or recommendations which were previously made or acted upon at a time when this authorization was in full effect.

I acknowledge that a copy of my medical record and treatment documentation may be sent to any of my healthcare providers for purposes of, among other things, continuity of care and treatment. Pursuant to this Patient Consent Form, I hereby authorize Apothikor Wellness to contact my healthcare provider(s) in order to obtain medical information and discuss aspects of my treatment and progress in controlling my health condition and/or for a recommendation for further evaluation.

If the individual receiving treatment is a minor or has a caregiver whom medical decisions are authorized by, please indicate below:

The individual is a minor or has a caregiver who authorizes medical decisions:

Authorization Request

I understand that authorization for an individual other than myself will require valid authorization (ex. Power of attorney) signed by all required parties and delivered to Apothicor LLC.

(Name of Patient)

(Date of Birth)

(Signature of Patient or Authorized Person if Applicable)

(Relationship to Patient if Applicable)