PATIENT CONFIDENTIALITY AND PEER REVIEW

Our practice policy has always been and will continue to be strict patient confidentiality regarding visits and treatment in our facility. In order to maintain certification by The American Association For Accreditation Of Ambulatory Surgical Facilities, Inc. (AAAASF) and to provide the highest quality of care to our patients, the record of your treatment may be reviewed for the purpose of medical quality assurance and peer review. Your name and all photographs will not be divulged to members of the peer review team. At all times we will maintain strict patient confidentiality. We appreciate your consent in continuing to allow us to maintain the highest quality of care for our patients and by signing this consent form you are assuring that process.

PEER REVIEW CONSENT FORM

I authorize Dr. David Rasmussen to disclose complete information concerning his medical findings and treatment of the undersigned, from the initial office visit until the date of the conclusion of such treatment, to those individuals who are required to receive such information for the purpose of medical treatment, medical quality assurance and peer review. I understand that my name, identity and, photographs will not be divulged for this purpose and that my privileges of confidentiality will not be waived.

PATIENT'S SIGNATURE: _____DATE:_____

WITNESS: _____