General Consent Form

Client Name : _____

Date of Birth : _____ (mm/dd/yy) Daytime Phone No:_____

Mailing Address:_____

Umangini Desai has been in practice since 1999 in the United states of America. She graduated from B.H.M.S Bachelor of Homeopathy, Medicine and Surgery with well accredited Sardar Patel Universtiy in India. Umangini Desai is registered with The North American Society of Homeopaths [RSHom (NA)] and is certified with the Council for Homeopathic Certification (CCH).She has agreed to abide by the Code of Ethics of each of these organizations.

Homeopathy views health and illness in a holistic manner and this view is different from the standard, conventional approach which usually limits its concerns to individual symptoms. In working with the whole person the homeopath regards the mental and emotional as well as physical aspects as important. A minor aggravation or worsening of some symptoms may occur as a part of the general healing process.

CONFIDENTIALITY

I understand that all information disclosed is confidential and may not be revealed to anyone without written permission, except where disclosure is required by law. Disclosure may be required in the following circumstances: a reasonable suspicion of child or elder abuse; a reasonable suspicion that a client presents a danger to him or herself or to others.

CONSULTATION

I authorize discussion of my case notes with other professional homeopaths should assistance in remedy selection and/or symptom analysis be required (for myself or my child) or my best interest be served by such a consultation. In so doing, my right to privacy will be protected by withholding my name and all other identifying information.

CONSENT

I am over 18 years of age and have voluntarily chosen homeopathic treatment for myself/for my child. I understand that Umangini Desai is a homeopath and not a medical doctor, and it is therefore recommended that I retain the services of a primary care physician for appropriate evaluations and check-ups for myself/for my child. I further understand that Umangini Desai does not diagnose, treat or prescribe for any particular symptom, disease or condition. I understand that he/she will work on increasing my/my child's general vitality and constitutional strength.

_____

Signature

_____

Date

AUTHORIZATION FOR RELEASE OF INFORMATION

Client Name _____

Date of Birth _____

I, _____, hereby give permission to

_____to communicate freely with other health care

professionals on my behalf as named below:

_____ _____
Name of Health Care Practitioner Telephone number

_____
Address

_____ _____ _____
Name of Health Care Practitioner Telephone number

_____
Address

I further acknowledge that the reason information is to be released was fully explained to me and this consent is given of my own free will. I would like a copy of this release of information
___ yes ___ no ___ initials.

_____
Signature

_____
Date

AUTHORIZATION TO PUBLISH OR TEACH (WRITTEN AND/OR VIDEO MATERIALS)

Client Name _____

Date of Birth _____

I, _____hereby give my consent to the presentation of the essential elements of my case notes for the purposes of homeopathic education at a conference or seminar or homeopathic school or college. I understand that this teaching material may be published in a professional (homeopathic) journal.

I understand that confidentiality will be preserved at all times and that:
• my real name (as above) shall not be used at any time (initials or another name will be used)
• all identifying characteristics and details shall be removed and not used

I understand that this information shall serve to further the progress of homeopathy by advancing the education of homeopathic students and practitioners.

I further understand that I may withdraw my consent at any time and that all teaching materials relating to my case will be withdrawn and destroyed, and I shall be advised of this in writing.

I confirm that this consent is given of my own free will and my signature below is entirely voluntary.

I would like a copy of this release of information ___ yes ___ no ___ initials.

_____ _____
Signature of Client Date

Practitioner

I, _____(**Please print your name)** have read the above statement and I understand and accept it. I agree to abide by the North American Society of Homeopath's Code of Ethics in the presentation of this patient's case.

_____ _____
Signature of Homeopath Date