PATIENT CONSENT FORM

Sushrut Hospital & Sushrut Piles Clinic

Website: https://sushrutpilesclinic.com/

1. Patient Information

Patient Name: _____

Age: _____

Mobile Number: _____

Email Address: _____

Date: ____ / ____ / _____

Select Clinic Location:

☐ Sushrut Hospital – Pimple Gurav

☐ Sushrut Piles Clinic – Old Sangvi

☐ Sushrut Piles Clinic – Moshi

2. Consent for Collection of Personal Information

I voluntarily provide my personal information, including my name, contact details, and other necessary information, to Sushrut Hospital and Sushrut Piles Clinic for patient registration, appointment booking, and healthcare services.

3. Consent for Medical Information

I understand that my medical history, symptoms, diagnostic reports, prescriptions, and treatment details may be collected and maintained for consultation, diagnosis, treatment, and continuity of healthcare.

I understand that my medical information will be treated confidentially and handled in accordance with applicable privacy laws.

4. Consent for Communication

I authorize the clinic to contact me through the following channels regarding appointments, consultations, and healthcare-related follow-ups:

☐ Phone Calls

☐ SMS

☐ WhatsApp

☐ Email

5. Consent for Medical Records

I understand that the clinic may maintain my medical records and relevant treatment information for healthcare, administrative, legal, and professional purposes.

6. Optional Consent for Photographs and Videos

I understand that photographs or videos may sometimes be required for medical documentation.

Please select your preference:

☐ I consent to photographs or videos for my medical records.

☐ I separately consent to the use of anonymized medical photographs or case details for educational purposes.

☐ I separately consent to the use of my photographs, videos or testimonials for the clinic's website and promotional activities.

I understand that promotional consent is optional and refusing it will not affect my treatment.

7. Patient Declaration

I confirm that the information provided by me is accurate to the best of my knowledge.

I have read and understood this consent form and agree to the collection and use of my information for the purposes explained above, where consent is the applicable legal basis.

I understand that I may withdraw my consent where legally permitted, subject to applicable medical record-retention requirements.

8. Patient / Guardian Signature

Patient Name: _____

Patient Signature / Thumb Impression: _____

Date: ____ / ____ / _____

Parent / Legal Guardian Name (if applicable): _____

Relationship with Patient: _____

Guardian Signature: _____

9. Clinic Contact Information

Sushrut Hospital & Sushrut Piles Clinic

Phone:

- 9096901123
- 08149740499

Email: dr.p.madhu.rao@gmail.com

Clinic Addresses:

Pimple Gurav:

M.K. Chowk, above HDFC Bank, Kawade Nagar, Trimurti Colony, Pimple Gurav, Pimpri-Chinchwad, Pune, Maharashtra – 411061, India.

Old Sangvi:

Ganpati Chowk, Shitole Nagar, Old Sangvi, Pimpri-Chinchwad, Maharashtra – 411027, India.

Moshi:

Shop No. 19–20, Silver Central Mall, Jadhavwadi, Chikhali, Moshi, Pimpri-Chinchwad, Maharashtra – 411062, India.

Important Note: This consent form covers patient information collection, medical records and communication preferences. It does not replace a separate informed medical consent form for laser treatment, surgery, Ksharsutra therapy, anaesthesia or any other medical procedure.