



**Faculty Group Practice
PATIENT CONSENT FORM FOR INTERPRETER SERVICES**

I understand the NYU Faculty Group Practice's policies to ensure equal access to all patients regardless of language or physical limitations. I hereby give my permission for Doctor _____ to use language interpreter services for the purpose of communicating medical information. I understand that the interpreter will have access to my medical information only through the interpretation of this information. The interpreter will NOT have access to my permanent written or electronic medical records. I also understand that this service will be provided at no cost to me personally.

Language Interpretation required: _____

Interpreter Name: _____
Print Name

Interpreting Service Provider: _____

Permission Granted by: _____
Print Name of Patient or Parent/Guardian

Signature of Parent or Guardian

Date: _____

Witnessed by: _____
Practice Representative – Name & Title