

MEDICAL CONSENT FORM

Patient Name: _____ Date of Birth: _____

Emergency Contact Information:

Full Name: _____

Relationship: _____

Phone Number: _____

Medical History and Information:

Please list any known allergies, medical conditions, medications currently taking, past surgeries, or other relevant health information:

Consent for Treatment:

I hereby give my consent for medical examination, diagnosis, and treatment by the attending physician and medical staff. I understand that the practice of medicine is not an exact science and acknowledge that no guarantees have been made to me regarding the outcome of any treatment or procedure.

Authorization to Release Medical Information:

I authorize the release of my medical records and information to my insurance company, health care providers, and other entities as necessary for treatment, payment, and health care operations. I understand this authorization may be revoked at any time by providing written notice, except to the extent that action has already been taken.

Patient Rights and Responsibilities:

I acknowledge that I have been informed of my rights as a patient, including the right to confidentiality, to participate in treatment decisions, and to refuse treatment to the extent permitted by law. I agree to provide accurate and complete health information and to follow prescribed treatment plans.

Limitation of Liability:

I release and hold harmless the medical provider and its employees from any liability for any injury, loss, or damage resulting from the provision of health care, except where caused by gross negligence or willful misconduct.

Severability:

If any provision of this Consent Form is found to be unlawful, void, or for any reason unenforceable, then that provision shall be deemed severable from this Consent Form and shall not affect the validity and enforceability of any remaining provisions.

Governing Law:

This Consent Form shall be governed by and construed in accordance with the laws of the United States and the state in which the medical services are provided, without regard to conflict of laws principles.

Acknowledgment and Signature:

By signing below, I acknowledge that I have read and understand the contents of this Medical Consent Form, that my questions have been answered to my satisfaction, and that I voluntarily consent to the medical examination and treatment described above.

PATIENT SIGNATURE

WITNESS SIGNATURE

Signature: _____

Signature: _____

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