MEDICAL CONSENT FORM

Patient Name: _____ Date of Birth: _____

Address: _____

Contact Number: _____ Email Address: _____

Medical Information:

Known Allergies: _____

Current Medications: _____

Existing Medical Conditions: _____

Consent Details:

I hereby give my consent to the medical treatment deemed necessary by the attending healthcare professional, including but not limited to examinations, diagnostic procedures, medication administration, and emergency care. I acknowledge that no guarantees have been made to me about the results of such treatments.

Privacy and Data Protection:

I understand that my personal and medical information will be handled in accordance with applicable data protection laws and used solely for the purposes of providing medical care and treatment. I consent to the disclosure of my medical information to other healthcare professionals as necessary for my treatment.

Emergency Contact Information:

Name: _____

Relationship: _____

Contact Number: _____

Acknowledgment and Signature:

I confirm that I have read and understood the above information and consent to the medical treatment as described. I have had the opportunity to ask questions and all my questions have been answered to my satisfaction.

PATIENT'S SIGNATURE

Signature: _____

WITNESS'S SIGNATURE

Signature: _____