

# 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**

**WITNESS'S SIGNATURE**

Signature: \_\_\_\_\_

Signature: \_\_\_\_\_

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