MEDICAL TREATMENT CONSENT FORM

Welcome to _____, located at _____.
Please read this document carefully. Feel free to request a discussion or ask questions of your physician before signing.

1. **AUTHORIZATION.** I authorize the performance upon _____ of such appropriately indicated physical examinations, x-rays, laboratory and other routine diagnostic procedures and treatments as my/the patient's physician or others of the facility's medical staff consider to be necessary or appropriate for the purpose of diagnosis of my/the patient's condition. I understand that the nature of and the need for each procedure and treatment will be explained to me beforehand, and that I am free to refuse any one or all procedures or treatments if I so choose.

2. **FLUIDS.** I consent to the diagnostic study and/or disposal by the facility's authorities of any blood, urine, or other body fluids, stool specimens, or tissues which are obtained in accordance with routine hospital practice and governmental regulation. I further understand that HIV testing requires separate consultation and consent.

3. **MEDICATIONS.** I consent to the present and future prescription and/or administration of medicines or drugs listed in the facility's formulary or U.S. Pharmacopeia as may be deemed necessary by my/the patient's physician or others of the facility's medical staff in the course of my/ the patient's diagnosis and treatment with the understanding that the nature of and the need for such medicines or drugs will be explained to me beforehand, and that I shall always be free to refuse each and all of them if I so choose.

4. **POTENTIAL RISKS.** I understand that the explanation which will be given to me of the nature, intended purpose, and the reasonable foreseeable risks, consequences, complications, benefits, and alternatives of the examination(s), procedure(s), or treatment(s) which may be performed or used in the course of diagnosing or treating my/the patient's condition will not be exhaustive, and that other risks and complications may arise but the likelihood of their occurring is not reasonably foreseeable. I have been advised that if I desire a more detailed explanation prior to my consent such explanation will be given to me.

5. **POTENTIAL BENEFITS.** I acknowledge that I have received no warranties or assurances with respect to any benefits which are hoped to be realized, or consequences which may result, from any of the examination(s), procedure(s) or treatment(s) which may be performed or used. I understand that the practice of medicine is not an exact science, and that diagnosis and treatment may involve risks of injury and even death.

6. **PHOTO/VIDEO.** I consent to the photographing and/or videotaping of the appropriate portions of my body, which are pertinent to showing my physical condition, for medical, scientific or educational purposes, provided reasonable precautions are taken to conceal my identity.

7. **ACKNOWLEGEMENT.** I acknowledge that I have read this document in its entirety and that I fully understand it prior to my signing. I understand that I am to make any inquiries regarding any aspect of my diagnosis or treatment which I do not understand. I represent to my/the patient's physician and the medical facility that I am eligible to give this consent.

Patient Signature: _____ Date: _____
Print Name: _____

Witness Signature: _____ Date: _____
Print Name: _____ Relationship to Patient: _____

Heath Care Agent Signature: _____ Date: _____
Print Name: _____ Relationship to Patient: _____

Legal Guardian Signature: _____ Date: _____
Print Name: _____ Relationship to Patient: _____

Interpreter/Translator Signature: _____ Date: _____
Print Name: _____