Consent to Treat

Authorization for Medical and/or Office Surgical Procedures

I understand that proper diagnosis and treatment may require the physician to perform minor surgical and medical procedures and treatments and to administer local anesthetics, medicines, x-rays, and other tests and medical procedures. I, therefore, authorize such operations, diagnostic procedures, treatments and administrations were performed by physician, nurses, and technicians.

I understand that most laboratory specimens collected at this facility are sent to an outside laboratory, which bill the patient unless covered under a health insurance policy.

I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been or will be made to me as in the results of treatments or examinations.

I authorize the release of my medical records, including diagnosis, treatment, procedures, and recommendations to my family medical doctor or referring physician, and if necessary to my insurance carrier.

I am fully aware of the contents of this form that I am signing, and understand that I may withdraw consent by crossing out and initialing any section above.

_______________________________________ ___________

Patient signature or Responsible Party Date

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Witness