Consent for Neurological Health Examination

Date: _____

Patient Name: _____

Date of Birth: _____

Address: _____

Phone: _____

To Whom It May Concern:

I, the undersigned, hereby give my consent for a neurological health examination to be performed by Dr. _____ at _____ (Facility Name).

I understand that this examination may include the assessment of my neurological function, which could involve neurological tests, imaging studies, and other assessments as deemed necessary by the physician.

Purpose of the Examination:

The purpose of the examination is to evaluate my neurological health and determine any necessary steps for further treatment or diagnosis.

Risks and Benefits:

I have been informed of the potential risks and benefits associated with this examination, and all my questions have been answered to my satisfaction.

Confidentiality:

I understand that my medical information will be kept confidential and will only be shared with necessary personnel involved in my care.

Signature:

_____

Patient Signature

_____

Signature of Guardian (if applicable)

Witness:

_____

Witness Signature