Medical Treatment Consent Form

Date: _____

Patient Name: _____

Date of Birth: _____

Address: _____

Phone Number: _____

Outpatient Services Consent

I, the undersigned, hereby consent to the performance of outpatient medical treatment as recommended by my healthcare provider. I understand that the specific nature of the treatment has been explained to me, and I have had the opportunity to ask questions.

Description of Treatment:

_____

Risks and Benefits:

I have been informed of the risks and benefits involved with the treatment. I understand that no guarantee can be made regarding the outcome of the treatment.

Alternative Treatments:

I have been made aware of alternative medical treatments that may be available to me.

Confidentiality:

I understand that my medical information will be kept confidential in accordance with healthcare regulations.

Signature:

_____

Patient/Guardian Signature

Printed Name:

_____

Witness:

_____

Witness Signature