Consent to Treat Form

Hospital Settings

Patient Full Name

_____

Date of Birth

_____

Medical Record Number (if applicable)

_____

Purpose of Consent

I hereby authorize the physicians, nurses, and other healthcare professionals at this hospital to render such care, treatment, and procedures as may be deemed necessary for my health and wellbeing. I understand that this consent includes, but is not limited to, examinations, diagnostic procedures, medical and/or surgical treatment, and emergency care.

Patient Rights

- I have the right to be informed about my condition, treatment options, and possible outcomes.
- I have the right to refuse treatment and to receive information regarding the consequences of my decision.
- I have the right to ask questions and receive timely responses.

Special Instructions or Allergies (specify if applicable)

_____

Consent

☐ I have read or had explained to me the information on this form. I understand and agree to the treatment and procedures described above.

_____

Patient/Guardian Signature

Date _____

_____

Witness Signature

Date _____