Patient Consent and Information Disclosure Form

Personal Information

Patient Name:

Date of Birth:

Contact Number:

Address:

Consent to Treatment

I hereby authorize and consent to the medical treatment and procedures as may be deemed necessary by my healthcare provider. I have been informed of the nature and purpose of the treatment, potential risks, and alternatives.

☐ I consent to the proposed medical treatments and procedures.

Information Disclosure

I understand that my personal and medical information may be disclosed to other healthcare professionals or institutions as necessary for my treatment, billing, or legal compliance, in accordance with applicable laws and regulations.

☐ I consent to the disclosure of my information as described above.

Additional Notes / Specific Instructions

Patient Signature:

Date:

Guardian/Representative (if applicable):

Date: