Medical Consent Form

Patient Name: John Doe

Date of Birth: 15/06/1985

Address: 456 Maple Street, Springfield

Phone: +1 234 567 8901

Emergency Contact: Jane Doe (+1 345 678 9012)

I, John Doe, authorize Dr. Emily Carter and the medical staff at Springfield General Hospital to provide necessary medical treatment, including diagnostic procedures, anesthesia, and medications.

I acknowledge that I have been informed about the nature of the treatment, potential risks, and alternative options. I consent to the use of my medical records for treatment purposes.

Patient Signature: _____

Date: 02/03/2025

Doctor's Name: Dr. Emily Carter

Doctor's Signature: _____

Date: 02/03/2025