Consent Form

Donor Details

Name : AP Singh
Donor Email: ap@gmail.com
Donor Age: 1
Donor D.O.B: 06-05-2025
Blood Group: B-
Gender: Male
Donor Address: sdaasdasd

Treatment Details

District: Bareilly
Blood Center: Blood Center D
Treatment Center: Era Center
Block: BLOCKZ
Room No : Room 545
Doctor Name : Dr. Kirti Saran
Doctor Address: Chowk

I, **AP Singh**, give my consent to the above-mentioned Blood Center to share my health and treatment-related details with the appropriate Treatment Center, if required. I understand the purpose of this and agree to the terms voluntarily.

Signature: _____

Date: 21/05/2025