MEDICAL TREATMENT

CONSENT FORM

STEP 1: PATIENT INFORMATION

I, _____ (Patient's Name) of, _____ (address), _____ (city, state, zip), hereby give my consent to the following medical treatment: *Provide Procedure/Treatment Name, Description, Date and Time of Procedure/Treatment, and Location.*

STEP 2: MEDICAL PROVIDER INFORMATION

I hereby give consent to _____ (Medical Provider), License No. _____, of _____ (Provider's Address), to administer the above-mentioned treatment.

STEP 3: EMERGENCY CONTACT

Contact Name: **Relationship:**

Phone Number:

STEP 4: CONSENT AND DISCLAIMERS

I understand that there are risks associated with any medical treatment and that the Medical Provider has explained these risks to me. These may include but are not limited to *(list specific risks here)*. I acknowledge that no guarantees or assurances have been made to me concerning the results of this treatment.

Furthermore, I consent to the use and sharing of my personal data for the following purposes *(List the purpose(s) for which personal data may be used and shared with third parties, if applicable. e.g. medical research and analysis or referral to specialists).*

STEP 5: SIGNATURES

By signing below, the Patient and Medical Provider acknowledge that they have read and agreed to the terms of this Medical Consent Form.

PATIENT SIGNATURE:	DATE:
MEDICAL PROVIDER SIGNATURE:	DATE: