Office Use: Chart # _____

Authorization to Treat

I hereby agree to and give consent to the physicians, healthcare providers, associates, consultants, and residents of John A. Martin Primary Health Care Center to diagnose and treat me. I consent to any and all treatment including, but not limited to, physical examinations, psychological examinations, x-rays, laboratory procedures, and other procedures related to routine diagnosis and treatment as determined appropriate by the practice's physicians, healthcare providers, associates, consultants, and residents.

_____

Printed Name of Patient

_____ _____

Signature of Patient Date

OR

_____

Printed Name of Patient's Representative

_____ _____

Signature of Representative Date

_____

Representative's Relationship to Patient

_____ _____

(Office Staff) Witness Signature Date