CONSENT FOR TREATMENT

Patient Name: _____

Patient Date of Birth: _____

Patient Address: _____

_____

PLEASE NOTE: Do not sign this form without reading and understanding its content.

- I consent to routine medical care rendered by the attending physician(s) at MedLink Georgia
- I consent to treatment by a Physician's Assistant or Advanced Practice Nurse acting under the supervision of a MedLink Georgia Physician
- I acknowledge that I have the right to explanations about my care and treatment in a language and manner that ensures I understand treatments and options
- I acknowledge that I have the right to refuse treatment after risks and benefits have been explained
- I understand that some persons furnishing professional medical services, including, but not limited to laboratory and pathology services, may be independent contractors and will bill separately for their services
- I acknowledge treatment may be rendered in an emergency without further consent

Signature of Patient or Legal Guardian	Relationship	Date

FOR MINOR PATIENTS AND/OR ADULTS UNABLE TO SIGN FOR THEMSELVES

- I attest that I am the legal guardian or parent of the patient
- I acknowledge that Georgia law and Federal regulations allow minor children to receive treatment in certain situations without parental/guardian approval (i.e., family planning, sexually transmitted diseases, pregnancy, substance abuse, etc.)
- I acknowledge that emancipated minors do not require parental/guardian consent for treatment
- I acknowledge that persons temporarily standing in for parents (in loco parentis) may consent for a minor in his/her custody
- I acknowledge the expectation that I will send written authorization for someone other than a parent or guardian or those listed below to accompany my child or adult unable to sign for themselves

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

Signature of Patient or Legal Guardian	Date

O-245-F
(4-2015)