CONSENT TO TREATMENT FORM

Patient Name: _____

Date of Birth: _____

1. Authorization for Treatment:

I hereby voluntarily consent to medical, surgical, and dental treatment, including diagnostic procedures, as deemed necessary or advisable by the attending healthcare providers. I understand that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me regarding results of treatments or procedures.

2. Risks and Benefits:

I understand that all medical and surgical procedures involve some risks and benefits, including possible complications, side effects, and adverse reactions. I acknowledge that these risks have been explained to me and that I have had the opportunity to ask questions and receive satisfactory answers.

3. Alternatives:

I understand that alternatives to the proposed treatment, including no treatment, have been explained to me. I have considered these alternatives and choose to proceed with the recommended treatment.

4. Confidentiality and Privacy:

I understand that my personal health information will be kept confidential in accordance with applicable federal and state laws, including the Health Insurance Portability and Accountability Act (HIPAA). I authorize the release of my health information as necessary for treatment, payment, and healthcare operations.

5. Voluntary Consent:

I acknowledge that I have read and fully understand this Consent to Treatment Form and that all of my questions have been answered. I understand that I may withdraw my consent at any time by notifying my healthcare provider in writing.

6. Patient Rights:

I understand my rights as a patient, including the right to refuse treatment, the right to receive information about my condition and treatment options, and the right to privacy and confidentiality.

7. Minors and Legal Guardians:

If the patient is a minor or otherwise unable to consent, this form must be signed by a legal guardian or authorized representative. The signer asserts they have the legal authority to consent to treatment on behalf of the patient.

8. Emergency Treatment:

In the event of an emergency, I consent to the administration of emergency medical treatment as deemed necessary by healthcare personnel.

9. Acknowledgment of Receipt of Privacy Practices:

I acknowledge that I have been provided with a copy of the Notice of Privacy Practices, which explains how my health information is used and disclosed.

10. Governing Law and Jurisdiction:

This Consent to Treatment Form shall be governed by and construed in accordance with the laws of the United States and applicable state law. Any disputes arising hereunder shall be subject to the exclusive jurisdiction of the courts of the appropriate state or federal venue.

Signature Section:

Patient or Legal Guardian Name:	**Date:**
Signature:	Witness Name:
Witness Signature:	Date: