## Consent to Treatment

I consent to the procedures which may be performed during this outpatient visit, including emergency treatment or services, and which may include, but are not limited to, laboratory procedures, diagnostic procedures, blood and/or urine specimens for substance abuse (drug/alcohol) screenings, x-ray examination, medical or nursing treatment or other physician or clinic services rendered to me as ordered by my physician or other healthcare professional.

This consent includes testing for communicable or blood-borne diseases, including, without limitation, Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) and Hepatitis if a physician orders such test(s) for diagnostic and/or treatment purposes. Agree __________ Disagree ________ (initials)

I understand that in the case of an accidental exposure to blood or other body fluids, state law allows the medical practice to test a patient who may have exposed a health care worker to HIV without obtaining the person's consent.

## Notice of Privacy Practices

I acknowledge that I have received the medical practice's notice of privacy practices, which describes the ways in which the medical practice may use or disclose my healthcare information for its treatment, payment, healthcare operations and others described and permitted uses and disclosures. I understand that I may contact the medical Privacy Officer if I have a question or complaint.

Acknowledge: __________ (initials)

I, as the patient, parent, guardian, spouse, guarantor or agent of the patient, certify that I have read, or have read to me, and understand this Consent to Treatment. I have signed this Consent to Treatment knowingly, freely, voluntarily. I have received no promises, assurances or guarantees form anyone as to the results that may be obtained by any medical treatment or services.

______________________________ ______________________

Patient or Patient's Legal Representative* Signature — Date

Print Name: ______________________

If signed by other than patient, indicate relationship: ______________________

**Authorized representative must submit copies of legal document supporting his or her authority to act on the patient's behalf.*

______________________________ ______________________

Witness Signature — Date

Witness Name: ______________________