

Medical Treatment Consent and Release Form

Please read this form carefully and fill out all sections completely prior to receiving medical treatment.

1. Patient Information

Full Name:

Date of Birth:

Address:

Phone Number:

2. Emergency Contact Information

Emergency Contact Name:

Relationship to Patient:

Emergency Contact Phone:

3. Consent for Medical Treatment

I hereby authorize the medical staff, physicians, and representatives of the healthcare facility to administer necessary medical treatment, diagnostic procedures, and therapeutic care as deemed necessary for my health and well-being.

4. Release of Liability and Medical Records

I authorize the release of any medical information necessary to process insurance claims and coordinate my care. I release the healthcare facility, its employees, and agents from any liability arising from the administration of authorized treatment, provided such treatment is administered in accordance with standard medical practices.

5. Acknowledgment and Signature

By signing below, I acknowledge that I have read, understood, and agree to the terms of this Medical Treatment Consent and Release Form.

Signature of Patient or Legal Guardian:

Printed Name of Signatory:

Relationship to Patient (if signed by Guardian):

Date: