Medical Treatment Consent Waiver

I, the undersigned, hereby authorize and consent to the administration of medical treatment that may be deemed necessary by medical professionals for myself or for the minor named below. I understand and acknowledge the nature of the proposed treatment and the possible risks involved. I agree to provide accurate and complete information regarding my/the patient's health history and current condition.

Patient Information

Full Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Address: _____

Phone Number: _____ Emergency Contact: _____

Consent and Release

- I understand that all reasonable measures will be taken to safeguard health and safety during medical treatment.
- I acknowledge that no guarantee has been made regarding the result of treatment or examination.
- I release the attending medical professionals and institution from liability for any adverse outcomes resulting from standard medical procedures, except in cases of gross negligence or willful misconduct.
- If the patient is a minor or unable to consent, I certify that I am the parent/guardian/legal representative authorized to give medical consent on their behalf.

I have read and fully understand this consent and waiver, and all of my questions have been answered to my satisfaction.

Signature of Patient / Guardian:

_____

Date: _____

Name of Patient / Guardian (Print):

_____

Relationship to Patient (if applicable): _____