Blank Medical Treatment Consent Waiver Form

Please complete all relevant fields.

Patient Information

Full Name

Date of Birth

Phone Number

Address

Treatment Information

Describe Treatment

Date of Treatment

Consent Statement

I hereby authorize and consent to the above-mentioned medical treatment. I acknowledge that I have been informed of the purpose, risks, benefits, and alternatives regarding this treatment. I understand that I have the right to ask questions and withdraw my consent at any time.

Waiver Statement

I acknowledge that no guarantees have been made as to the results of the treatment. I further agree to release the medical provider and its staff from any liability arising from the procedure, except for acts of negligence.

Patient/Guardian Signature

Print Name

Date

Provider/Witness Signature

Print Name

Date