Blank Informed Consent and Waiver for Medical Care

I,

Full Name

, hereby acknowledge that I have been informed about the medical care and procedures recommended/provided by

Healthcare Provider/Facility

.

I understand the nature, risks, benefits, and alternatives involved in my medical care. I have had the opportunity to ask questions and all of my questions have been answered to my satisfaction.

I understand that no guarantee has been made as to the results that may be obtained.

Consent

I voluntarily give my consent to receive the proposed medical care, treatment, or procedure. I affirm that I am of legal age or otherwise authorized to provide consent.

Waiver

I hereby release and hold harmless

Healthcare Provider/Facility

, its employees, and agents from any and all liability for injury or adverse outcomes arising from my decision, except for those resulting from gross negligence or willful misconduct.

Patient/Authorized Representative Signature:

Signature

Date:

Provider/Witness Signature:

Signature

Date: