CONSENT TO MEDICATION/TREATMENT FORM

Patient Name: _____
Date: _____

CONSENT TO TREAT

I, the undersigned, hereby voluntarily consent to the rendering of such care, including diagnostic procedures, medication management, mental health treatment, by authorized practitioners and their designees/students as may in their professional judgment be necessary. I understand that this consent is given in advance of any specific diagnosis or treatment.

I understand that I have the right to ask and receive an explanation about any medication recommended, possible alternatives, side effects, drug interactions, and possible complications. I voluntarily agree that this consent will cover agreed upon medication changes and no new consent is required for medication changes. I understand that I have the right to refuse any medication or treatment, or to change my mind later and withdraw consent for treatment.

This consent form is valid until revoked by the patient.

Please note that it is important to read and understand all information provided above before signing this form.

RELEASE OF INFORMATION:

I hereby authorize the release of any medical or other information necessary to process insurance claims. I also authorize payment of medical benefits to the undersigned physician or supplier for services rendered.

ACKNOWLEDGEMENT:

I have read and understand the above consent for medications and to treat, and I agree to all of the above.

Patient Signature: _____

Date: _____

If patient is a minor or unable to consent:

Name of Parent/Guardian: _____

Relationship to Patient: _____

Parent/Guardian Signature: _____

Date: ____