Consent for Treatment

By signing this consent, I am authorizing my physician and/or other individuals, she deems appropriate, to perform and/or order exams, tests, procedures and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to The Strittmatter Center for Wellness unless revoked by me orally or in writing.

Please be information that Texas Law allows a patient to be tested for Human Immunodeficiency HIV, the virus with AIDS in the following situations: 1) to screen blood products, organs or tissues to determine suitability for donation, 2) if another individual is accidentally exposed to a patient's blood or body fluids such as through a needle-stick, or 3) If a medical or surgical procedure is to be performed which could expose healthcare workers to the patient's blood or body fluids. This disclosure is to inform you that you may be tested to see if any of these situations occur during your treatment period.

Signature: _____ Date: _____

(patient or legal representative)

Relationship to Patient: _____ Date: _____

Witness: _____ Date: _____