CLEAR FORM PRINT FORM

MEDICATION CONSENT FORM

Patient Full Name:

Patient Date of Birth:

Medication Name	Dosing Range	Route of Administration	Medical Indication

Please review the following statements:

- The medication(s) listed above is/are being prescribed by
- The potential benefits and most common adverse effects have been discussed for each medication listed above.
- Alternative treatment options, if any, have been discussed for each medication listed above
- may discontinue prescribing any medication(s) listed above at any time during treatment if medically necessary based on his professional and medical judgment
- may discontinue prescribing any medication(s) listed above at any time during treatment if there is any suspicion of abuse or diversion.
- The medication(s) listed above is/are indicated only for the patient whose name is printed on this form.
- The medication(s) listed above is/are to be taken as directed by
- The medication(s) listed above is/are not to be shared, distributed, or administered to anyone other than the patient whose name is printed on this form.
- The medication(s) listed above is/are recommended and not required by or mandated by any entity or law (i.e., taking any medication(s) listed above is/are voluntary)

I, _____, have read the above statements and I agree with the above statements. My signature below means I consent to medication treatment.

Patient Full Name (Print):

Patient Signature:

Date:

Provider Full Name (Print):

Provider Signature:

Date: