Kentucky Mountain Health Alliance, Inc.

CONSENT TO TREATMENT FORM

MRN #: _____

I voluntarily authorize the rendering of such care, including diagnostic procedures, medical treatment, mental health/substance abuse services and dental treatment by authorized agents and employees of the Kentucky Mountain Health Alliance, Inc., and its medical staff, or their designees, as may in their professional judgement be deemed necessary or beneficial, and may include testing for HIV (the virus that causes AIDS) and other blood borne diseases. I acknowledge that no guarantees have been made as to the effect of such examination or treatment on my condition. I understand that I have the right to make decisions concerning my health care or the health care of the person for whom I am duly authorized to make such decisions, including the right to refuse medical and surgical procedures.

Patient Name (Print): _____

Date: _____ Patient Signature: _____

If patient is a minor OR unable to sign: Legal Guardian, Next of Kin, or Legal Agent can sign below:

Signature: _____

If patient is unable to sign, secure consent of Next of Kin or Legal Agent and indicate reason below:

( ) Minor
( ) Medically Unstable
( ) Disoriented
( ) Incompetent

Witness Signature (Employee Signature) : _____

(Revised 07/24/2023)