VOLUNTARY CARE
PATIENT CONSENT FORM

Patient's Name _____
(last name) (first name) (middle initial)

Date of Birth _____/_____/_____

Social Security Number _____ Telephone Number _____

Home Address _____
(street address) (city/state/zip code)

I hereby consent to the provision of diagnosis, care, and/or treatment by _____,
(health care provider)
and I hereby acknowledge that such consent will remain in effect unless and until I cancel such consent in writing.

I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the diagnosis, care and/or treatment and am not subject to duress or undue influence.

I HEREBY ACKNOWLEDGE AND UNDERSTAND THAT, BY SIGNING THIS VOLUNTARY CARE PATIENT CONSENT FORM, I AM GIVING INFORMED CONSENT TO THE PROVISION OF DIAGNOSIS, CARE, AND/OR TREATMENT BY _____ AND CANNOT BRING A TORT OR OTHER SIMILAR
(health care provider)
ACTION, INCLUDING AN ACTION ON A MEDICAL, DENTAL, CHIROPRACTIC, OPTOMETRIC, OR OTHER HEALTH-RELATED CLAIM,AGAINST _____ UNLESS THE ACTION OR OMISSION OF _____
(health care provider) **(health care provider)**
CONSTITUTES WILLFUL OR WANTON MISCONDUCT.

_____ _____
Signature of Patient or Person Authorized to Consent* Date

_____
Relationship (if not Patient)

* If this Consent for Treatment is signed by someone other that the patient, it must be signed in the patient's presence.