



General Consent to Treatment

Patient Name: _____

1. Consent to Ambulatory Service

I request and authorize the type of health care services listed above as my physician, his/her assistants or designees (collectively called "the physicians") advise. These include routine diagnostic, radiology and laboratory procedures, routine therapeutic procedures, routine drugs, and routine medical and nursing/hospital care. I understand that in emergencies it may be advised to expand or deviate from the service listed here in order to preserve my life or health. I understand that facility personnel care for me according to the physician instructions.

2. Consent to Testing and Disposal of Bodily Fluids and Tissue

I understand that the facility may perform non-diagnostic laboratory tests upon specimens of blood, urine and other bodily fluids/tissue that are withdrawn from me for diagnostic purposes, and the facility may dispose of these specimens as it chooses.

Signature of patient, parent or guardian

Date