

[PLACE ON APPLICABLE HEALTH CARE PROVIDER'S LETTERHEAD]

**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 [insert name of 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 [insert name of health care provider] AND CANNOT BRING A TORT OR OTHER SIMILAR ACTION, INCLUDING AN ACTION ON A MEDICAL, DENTAL, CHIROPRACTIC, OPTOMETRIC, OR OTHER HEALTH-RELATED CLAIM, AGAINST [insert name of health care provider] UNLESS THE ACTION OR OMISSION OF [insert name of 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 than the patient, it must be signed in the patient's presence.

[PLACE ON GROUP PRACTICE'S LETTERHEAD]

**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 [name of Group Practice] and its health care professionals and health care workers, 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 [name of Group Practice] AND ITS HEALTH CARE PROFESSIONALS AND HEALTH CARE WORKERS AND CANNOT BRING A TORT OR OTHER SIMILAR ACTION, INCLUDING AN ACTION ON A MEDICAL, DENTAL, CHIROPRACTIC, OPTOMETRIC, OR OTHER HEALTH-RELATED CLAIM, AGAINST [name of Group Practice], ITS HEALTH CARE PROFESSIONALS, OR HEALTH CARE WORKERS UNLESS THE ACTION OR OMISSION OF [name of Group Practice], ITS HEALTH CARE PROFESSIONALS, OR HEALTH CARE WORKERS 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 than the patient, it must be signed in the patient's presence.