

White River Rural Health Center, Inc.
CONSENT TO TREATMENT

Date _____

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1. I, _____, (the _____
(Name of person giving consent)
of _____), hereby voluntarily consent to outpatient care
_____ encompassing routine diagnostic procedures, examina-
(Clinic Name)
tion and medical treatment including (but not limited to) routine laboratory work (such as blood, urine
and other studies), taking of x-ray, heart tracing and administration of medications prescribed by the
physicians.
2. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical
treatment by the medical staff, their assistants, including physician's assistants or their designees as is
necessary in the medical staff's judgement.
3. RELEASE OF INFORMATION: (a) I authorize the clinic to release medical information to the party insur-
ance carriers for the purposes of filing insurance claims related to my (his/her) medical care, (b) I further
authorize the release of medical information about treatment here to my (her/her) doctor or any designated
by me.
4. I understand that this consent form will be valid and remain in effect as long as I (he/she) attend the clinic.
5. This form has been fully explained to me and I understand its contents.

COMMENTS: _____

Signature of patient or person authorized to consent for patient

Signature of staff who explained the contents of this consent form

If patient is a minor or is unable to consent, complete the following:

A. Patient is a Minor _____ years of age.

Name of Father _____ Name of Mother _____

B. Patient is unable to consent because _____

Signature of closest relative or

Relationship

Witness to representative's