## Consent for Treatment Form

Patient Information:

- Name: ____________________
- Date of Birth: ____________________
- Address: ____________________
- Phone Number: ____________________
- Email (optional): ____________________

I, the undersigned, hereby consent to receive medical treatment from Dr. _____________________________ at ***Florida Care Medical Center***. I understand that this treatment may involve medical procedures, medications, or other interventions as deemed necessary by the healthcare provider.

I have been provided with information about the proposed treatment, including its purpose, risks, benefits, alternatives, and potential complications. I have had the opportunity to ask questions and have received satisfactory answers to my inquiries.

I understand that I have the right to refuse or withdraw consent for treatment at any time, and that doing so may have consequences for my health. I acknowledge that the healthcare provider has explained these consequences to me.

I consent to the release of my medical information to other healthcare providers involved in my care, as necessary for continuity of treatment.

I certify that I am providing this consent voluntarily, without coercion or duress.

Patient signature: ____________________
Date: ____________________
Witness (if applicable): ____________________