Medical Consent Form for Adults

PATIENT INFORMATION

Full name: _____ Date of birth: _____ dd / mm / yyyy

Phone number: _____ Email: _____

Address: _____

EMERGENCY CONTACT

Full name: _____ Relationship to patient: _____

Phone number: _____

CONSENT FORM

I understand and acknowledge the following:

1. Nature of consent:

2. Nature of treatment:

3. Risks and benefits:

4. Privacy and confidentiality:

5. Financial responsibility:

6. Right to refuse or withdraw consent:

7. Communication and follow-up:

8. Authorization for medical decision-making:

9. Agreement and consent:

SIGNATURE

Patient's signature:
Date: _____ dd / mm / yyyy

Witness' signature:
Date: _____ dd / mm / yyyy