SCAN

CONSENT FOR EXAMINATION, DIAGNOSIS, TREATMENT AND MEDICAL CARE

I am presenting myself or _____
(Name of Patient)

My _____
(Relationship to Patient)

For examination, diagnosis, and treatment by the Physicians of Family Medicine Associates of Augusta, and other Physicians in practice with them or with whom they may consult and voluntarily consent to such examinations, diagnostic tests and procedures, and such other medical treatments, procedures and care as said physicians may deem necessary or appropriate in their professional judgment. Said tests, treatments, and procedures may be performed by the employees and agents of said physician(s).

Date _____

Patient's Signature _____

Signature
Parent/Guardian _____

Witness_____