CONSENT FOR MEDICAL TREATMENT

I, _________________________, understand and knowing that I am suffering from a condition requiring medical care, I hereby voluntarily consent to such care encompassing diagnostic procedures and medical treatment by Dr. Mark Vann, his assistants or his consignees as may be necessary in his judgment. I acknowledge that no guarantees have been made as to the result of treatments or examination in the hospital.

This form has been fully explained to me and I certify that I understand its contents.

___________________________________  __________________________
Patient or Personal Representative          Date

___________________________________
Witness

Patient:

_____________ Minor _____________ Unable to consent due to: ______________________________

______________________________________________________________________________

I hereby consent on his/her behalf and in his/her stead on ______________________________.

Date

Signature of Person Responsible for Patient or Patient’s Legal Guardian

___________________________________  __________________________
Signed          Printed Name