Essentia Health

# Consent for Treatment

## Consent for Medical Care

I consent to receive medical care at Essentia Health. My medical care may include routine tests and treatment that my doctors or my care team believe I need. I understand that my medical care and treatment may be given by doctors, nurse practitioners, physician assistants, nurses, students, and other health care professionals. I understand that Essentia Health cannot promise specific results. I understand that medical photographs and/or videos may be made of me as part of my care or treatment and that these may be used in my medical record and/or for medical teaching.

**By signing below, I state that** I have read, understand, and agree to this Consent for Treatment. I understand that I have the right to revoke/take back my consent at any time except where Essentia Health has already acted on my consent. I understand I must notify Essentia Health in writing if I want to take back my consent.

- **If the patient is 18 years of age or older**, the patient must sign and date the form.
- **If the patient is 18 years of age or older and is unable to sign**, a legally authorized person must sign and date the form. State your legal authority and give legal documentation if not already on file:
  □ Legal Guardian or Conservator □ Health Care Agent (Health Care Power of Attorney)
  □ Other Legal Representative _____
  Note: If none of these apply and this is a medical emergency, the signer has the following relationship with the patient _____
- **If the patient is 17 years or younger**, the patient's parent or legal guardian must sign and date this form, unless an exception exists under state or federal law. State your relationship:
  □ Parent □ Legal Guardian (Give legal documentation if not already on file)

_____ _____ _____
Signature Date Signed Time

Printed Name of the Person Signing *(If not Patient)* _____

_____
Witness (signature by mark must be witnessed)

**FOR ESSENTIA USE ONLY:**

**Patient encounter is for (check one):**

**[ ] Ambulatory care** – This consent is valid for one year.

**[ ] Series care -** This consent is valid until the end of the series.

**[ ] Inpatient or Emergency care –** This consent is valid for the patient's inpatient or ED stay.

**Note: Telehealth services are covered on the GCA**

Patient Name and Medical Record Number
Or Patient Label

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