



**CONSENT TO MEDICAL TREATMENT**

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

I am suffering from a condition requiring medical services, and hereby consent to the rendering of such care. Medical treatment may include routine diagnostic procedures and such medical treatment as the attending provider is authorized to perform by the State of New Hampshire.

\_\_\_\_\_  
Signature of Patient/Parent/Guardian

\_\_\_\_\_  
Date

If the patient is a minor, the signature of a parent or guardian is required.

If anyone other than the patient is signing, we need the of the signing adult along with their relationship to the patient.

\_\_\_\_\_  
Name

\_\_\_\_\_  
Relationship