McClinton ENT of Newnan, LLC
2301 Newnan Crossing Blvd, Ste 120
Newnan, GA 30265
Ph 770-683-2155; Fx 770-683-2154

CONSENT TO MEDICAL TREATMENT **Patient Name** _____

In consideration of medical services to be rendered to me (herein referred to as Patient) at McClinton ENT of Newnan, LLC (henceforth referred to as MENT), Patient does hereby consent as follows:

Consent and Treatment Authorization

Patient (or the undersigned acting on behalf of Patient), who is requiring medical treatment, does hereby consent to the rendering of such care and treatment, which may include diagnostic procedures and such medical treatment and care as the Physician and medical staff consider to be necessary and appropriate.

The consent to receive medical treatment includes, but is not limited to, examinations, diagnostic and therapeutic procedures, medications, infusions, transfusions of blood and blood products, surgery, anesthesia and any other medical treatment and services which Patient may require.

In the event that MENT should decide that blood specimens should be provided by the Patient for testing purposes in the interest of the safety of those with whom Patient may come in contact, Patient does hereby consent to such blood withdrawal and for the testing thereof, as well as to the release of test information where this is deemed medically appropriate or required by law.

Disclaimer of Guarantee

Patient hereby acknowledges that the practice of medicine and surgery is not an exact science and that diagnosis and treatment may involve risks of injury and of adverse results. Patient hereby acknowledges that no guarantees have been made to Patient or those acting for Patient as to the results of procedures which Patient may undergo while a patient of MENT.

Acknowledgements of Patient

Patient understands that:

a. It is customary, absent emergency or extraordinary circumstances, that no substantial or invasive medical procedures be performed upon a patient unless and until the patient has had the opportunity to discuss these procedures with the physician or other health professional so that the patient may be informed of the contemplated procedures.
b. Each patient has the right to consent, or refuse to consent to any specific procedure or therapeutic course of treatment. If Patient refuses to consent to the administration of blood or blood products, MENT reserves the right to decline to provide medical care if, in the opinion of the Physician, the refusal of blood products poses a serious threat to the Patient.

Patient Understanding of Consent

This Consent Form has been adequately and fully explained to Patient, and Patient, by his or her signature, indicates satisfaction as to an adequate understanding of this Consent and its significance and that Patient is voluntarily executing the same.

Authorization for Release of Medical Information

I hereby authorize the release of any medical information, including information related to psychiatric care, drug and alcohol abuse and HIV/AIDS confidential information, necessary to process insurance claims or any medical information that is required for any health care related utilization review or quality assurance activities as well as to other physicians for continuity of care issues.

Validity of Consent

This consent is valid during the entire term of my association with McClinton ENT of Newnan, LLC. and may be relied upon unless, and until, revoked by Patient, in writing.

_____

PLEASE INITIAL *(full signature/date below)*

PERMISSION TO AUTHORIZE TREATMENT AND PROVIDE HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

I hereby give my permission to the person(s) listed below to authorize treatment and receive information about the care of the above named patient. *In order to obtain information, the party calling must share the patient's date of birth or Social Security Number.*

_____ _____ _____ _____
(*print name*) *(relationship)* *(print name)* *(relationship)*

_____ _____ _____ _____
(*print name*) *(relationship)* *(print name)* *(relationship)*

SIGN HERE

_____ _____ _____
Patient Signature (Guardian or Rep. if patient is a minor) Relationship to patient if minor Date