TRINITY FAMILY MEDICAL CENTER, P.A.

Consent of Treatment

I, _____ am authorized and hereby give consent for the
Patient/Guardian Name

Medical staff of Practice Name Here to examine and render care to

_____. This consent will remain in effect
Patient Name Here

Until revoked in writing.

_____ _____

Signature of Patient/Guardian Date

Please provide Trinity Family Medical Center
With your driver's license and current insurance card.

Thank you!