

# 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!***