GISD EMPLOYEE CLINIC

General Consent to Clinic Services.

I (or my authorized representative, i.e., parent guardian), _________________________, consent to the medical treatment to be performed by the providers of GISD Employee Clinic Provider and Clinicians. This care may include, but is not limited to, administration of routine drugs and routine medical care. I understand that my (the patient's) care is directed by the provider and that other personnel render care and services to me (the patient) according to the provider's instructions.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees or promises have been made to me with respect to the results of treatment at GISD Employee Clinic.

I authorize GISD Employee to contact healthcare providers from whom I have received treatment to obtain medical information and/or records including pharmacies and other drug treatment records for verification of my medications.

I understand that I have the right to refuse any medical treatment recommended at any time.

I acknowledge that I have read (or had read to me) and fully understand the above information. Furthermore, I certify that all my questions and concerns have been explained to my satisfaction.

____ ___________________

Patient's Signature/Guardian/Power of Attorney Patient's Date of Birth

____ ___________________

Witness Signature Date

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