Medical Consent Form (General Use)

Name:		**Date of Birth:**	
Gender:	◯ Male ◯ Female ◯ Other:		
Email:		**Contact #:**	
Address:			

Proposed Treatment / Procedure
I, the undersigned patient, hereby consent to the following treatment/procedure:
Description of Treatment / Procedure
Risk and Potential Side Effects
I acknowledge that I have been informed of all potential risks and side effects associated with the treatment or procedure, including but not limited to:
I have had the opportunity to ask questions and seek clarification.
Alternatives to the Proposed Treatment
I am aware that alternative treatments or procedures may be available for my condition, and I have been provided information regarding these alternatives:

Benefits of the Treatment
I understand the expected benefits of the treatment or procedure, including:
Confidentiality and Privacy
I acknowledge that my personal information will be kept confidential and will not be shared without my explicit consent, except as required by law.
Right to Withdraw Consent
I understand that I have the right to change my mind and withdraw my consent at any time without facing any consequences. I can do so by contacting my healthcare provider.
Consent Confirmation
I have read and understood the information provided in this consent form. I willingly consent to the proposed treatment or procedure.
Patient's Name and Signature:
Date:
Witness's Name and Signature:
Date:
Hospital or Clinical Representative's Name and Signature:
Date:
Hospital Name:
Phone Number:
Email: