# PATIENT CONSENT FOR TREATMENT

Patient Name: _____
Last First MI

Date of Birth: _____ SSN: _____-_____-_____

I voluntarily authorize the rendering of such care, including diagnostic tests, procedures and medical treatment by authorized agents and employees of Triad Health Systems, Inc., and its medical staff, or designees as may, in their professional judgment, be deemed necessary or beneficial, and may include testing for HIV (the virus that causes AIDS) and other blood borne diseases. I acknowledge that no guarantees have been made as to the effect of such treatments of procedures on my condition. I understand that I have the right to make decisions about my health care or the health care of the person for whom I am legally responsible, including the right to refuse medical and/or surgical procedures

☐ I have formulated an Advance Directive (living will, health care surrogate, declaration, durable power of attorney) and request that these directives govern my care according to Kentucky state and/or federal laws. I understand that it is my responsibility to provide Triad Health System, Inc. with a copy of my duly executed Advance Directive and that those directives will not govern my care until they have been filed in my medical record.

☐ Advance Directive attached.

☐ Advance Directive not attached.

☐ I have not formulated an Advance Directive, but I understand that is my right to make decisions regarding my course of treatment, including the execution of an Advance Directive.

I certify that I have read and understand the authorization given above and that I am the patient or the patient's legal representative and may execute this consent and accept its terms. I understand that this consent may be revoked at any time except to the extent that action has already been taken.

_____ _____ _____
Patient Signature or Legal Representative: Relationship to Patient: Date:

_____ _____
Signature of Witness: Date: