

# Sherwood Family Medicine

## Consent for Treatment (General)

Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_

**I authorize treatment deemed medically necessary on the above named patient. I understand that if there are specific procedures I am scheduled for that I will sign a specific consent for each procedure. This consent is for general treatment needed when scheduled for care at Sherwood Family Medicine.**

Patient Signature: \_\_\_\_\_

Signature of Patient's Representative: \_\_\_\_\_  
(If patient is under 18)

Relationship of Representative: \_\_\_\_\_