



with MUSC Health

Patient Last Name

Patient First Name

Patient Middle Initial

Patient Date of Birth

# Ambulatory Consent for Medical Treatment

## Consent for Medical Treatment

I, \_\_\_\_\_, (as patient, parent, guardian, spouse, guarantor, or other responsible party), consent to and authorize medical treatment and diagnostic procedures which may be ordered and/or provided by my doctor and performed at Tribe513 ambulatory locations (Breastfeeding Center at Parkside, Brio Primary Care, Grace Internal Medicine, Parkside Family Medicine, Parkside OB-GYN, and/or Parkside Pediatrics with MUSC Health).

I understand that this consent for medical treatment, assignment of insurance benefits, and agreement of financial responsibility will be valid for one year from the date of signature and can only be revoked upon written notice.

Signature of Patient/Legal Representative

Date

Print Name of Patient/Legal Representative

Relationship to Patient