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Medical Clinic Consent Form for Surrogate Decision-Makers of Non-Decisional Adults

Patient Information

Patient's Full Name: _____
Date of Birth: _____
Address: _____
Phone Number: _____

Surrogate Decision-Maker Full Name: _____
Date of Birth: _____
Address: _____
Phone Number: _____
Relationship to Patient (child, parent, sibling, caregiver, etc.): _____

I, _____, have medical power of attorney for the above-named patient, AND can provide written documentation of the legal ability to make medical decisions on behalf of the above-named patient. **I understand that I must provide proof of medical power of attorney before any treatment can be provided.**

I consent to the treatment of the above-named patient and authorize medical and/or surgical treatment for the patient at Kinex Podiatry, by the healthcare providers associated with this clinic.

I understand that the treatment may include, but is not limited to, examination, diagnosis, laboratory tests, medical or surgical treatment, and medication administration. I acknowledge that there may be risks and benefits associated with any medical treatment, and I accept responsibility for making decisions regarding the patient's healthcare to the best of my ability.

I acknowledge that I have read and understand the contents of this consent form, and I have had the opportunity to ask questions and seek clarification regarding any concerns I may have.

My printed name: _____ Today's date: _____

My signature: _____ My phone number: _____

(Note: This form should be signed and dated by the surrogate decision-maker consenting on behalf of the non-decisional adult and kept in the patient's medical records for future reference. If required by state law, a witness may be necessary for the signature.)