Medical Treatment Authorization Form

Consent for Treatment:

I, the undersigned, a patient of Endure Urgent Care request and authorize my physician and whomever he/she may designate as his/her associates or assistants, to administer such treatment for.

- Myself
- My child as a parent or a legal guardian (if applicable)
- A family member or cared for individual as a legal representative/decision maker (if applicable)

I voluntarily consent to said medical care, evaluation and treatment as well as any information release necessary to obtain such. These would include, but not be limited to, examinations, diagnostic evaluations includes labs, imaging including X-rays, procedures, medical or surgical treatments

In the event that invasive procedures are deemed medically necessary, I further understand that additional consent will be obtained and this consent might be verbal or written as circumstances dictate. I am aware that the practice of medicine and surgery is no exact science and I acknowledge that no guarantees have been made to me as to the results of treatment or examination.

LABORATORY SERVICES: I acknowledge that certain lab tests may be sent to an independent lab for processing and hereby authorize results from these labs to be electronically delivered to Endure's electronic medical record system. I understand that I will receive a separate bill for test results processed by an independent lab and agree to be financially responsible for the lab services provided to me.

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Printed Patient Name Date

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Patient Signature