

Medical Consent Form

I, the undersigned, for myself or my child, hereby consent to medical care and treatment, as ordered by a provider, while such medical care and treatment is provided through Holston Medical Group on an outpatient/ office visit basis. This consent includes my consent for all medical services rendered under the general or specific instructions of a provider; including treatment by a mid-level provider (Nurse Practitioner or Physician Assistant), and other health care providers or the designees under the direction of a physician, as deemed reasonable and necessary.

I agree and acknowledge that Holston Medical Group is not liable for the actions or omissions of, or the instructions given by the physicians/providers who treat me while I am a patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as to the result of treatments or examinations at Holston Medical Group facilities.

Patient: _____

Date: _____

Parent (If Applicable): _____

Date: _____