MIDDLE GEORGIA STATE UNIVERSITY HEALTH CLINIC

CONSENT FOR TREATMENT

PATIENT NAME: _____ **DATE of BIRTH:** _____

MGA ID NUMBER: _____

CONSENT FOR TREATMENT

I hereby consent to receive medical care (or for my minor child or ward under 18 years of age to receive medical care) from Middle Georgia State University nursing staff at the Health Clinic in accordance with the standards of reasonable practice and after being informed of the associated risks and benefits. I also authorize such treatment and other diaga-1 (n)1.3(m)3(ag)8 wmmed agre fs (e)2ayagirca-1a(i)1.(e)2(so)1.yagenatnatirih auir