Consent for Medical Treatment

I hereby voluntarily consent to outpatient care from Hartford Orthopedic Surgeons' health care providers encompassing routine diagnostic procedures, examination, and medical treatment including (but not limited to) routine laboratory work, x-rays, and administration of medications as prescribed by the providers. I further consent to the performance of those diagnostic procedures, examinations, and rendering of medical treatment by Hartford Orthopedic Surgeons' medical Providers and staff, as is necessary in the medical staff's judgment.

I have the right to discuss the treatment plan with my physician about the purpose, potential risks and benefits of any test ordered for me. If I have concerns regarding any test or treatment recommended by my health care provider, I am encouraged to ask questions.

I understand that during the course of treatment, medical providers and staff may be exposed to blood and/or body fluids increasing their risk of contracting Hepatitis B, Hepatitis C, and/or HIV. In the event an exposure occurs, I understand the need for testing for these diseases and I agree to such testing of myself to promote the health and welfare of the health care worker.

By signing below, I am indicating that (1) I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) I consent to treatment at this office or any other office under common ownership. This consent to medical treatment will expire 12 months from the date signed until revoked in writing. I have the right at any time to discontinue services.

I hereby give my consent to treat minor child below, which is under the legal age of eighteen years of age, to receive medical care and/or treatment from the providers of Hartford Orthopedic Surgeons. Any care deemed medically necessary may be provided with or without my presence:

Child: ____ Date of birth ________________

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

[ ] Patient under 18 years of age
[ ] Patient unable to sign

____ __________________
Signature of Patient or Authorized Representative Date

____ __________________
Printed Name of Patient or Authorized Representative Relationship to Patient