UNITY HEALTHCARE ALLIANCE

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician(s) and/or order another person to perform all exams, tests, procedures, injections, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Dr. _____, with Unity Healthcare Alliance unless revoked by me in writing.

Birth Date #_____

_____ _____

Date *Patient/Legal Representative*

THCOBP12