## General Consent for Diagnosis and Treatment

***TO THE PATIENT:*** *You have the right to be informed regarding the recommended diagnostic, medical, and therapeutic procedures for your condition(s), so that you may decide whether to undergo suggested treatments and/or procedures after knowing the benefits and risks involved. This consent form is to obtain your permission to perform the evaluations necessary to identify the appropriate treatments and/or procedures for your identified condition(s).*

This consent provides Sonoran University clinics with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature, including after specific diagnoses and treatment recommendations have been made; and (2) you consent to treatment at this clinic or any other associated clinic within Sonoran University. You have the right to discontinue services at any time. This consent will remain fully effective until it is revoked by you in writing.

You have the right to discuss your treatment plan with your physician and/or other health care providers about the purpose, potential risks and benefits of any medical examinations, testing and/or treatment recommended for you. We encourage you to ask questions of your physician and/or other health care providers regarding any concerns you have.

I voluntarily request my physician and/or other health care providers to perform reasonable and necessary medical examinations, testing and/or treatment for the condition(s) which have led me to seek care at this clinic. I understand that if additional medical examinations, testing and/or treatment is recommended, I may be asked to read and sign additional consent forms prior to these exams, tests or treatment.

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

________________________________________
PATIENT NAME (printed)

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| SIGNATURE: Patient or legally authorized individual | DATE: |
| PRINT NAME: Patient or legally authorized individual | RELATIONSHIP: (self, parent, legal guardian, personal representative, etc.) |