Patient General Consent to Treat

I, the undersigned, hereby consent to the following;

- Administration and performance of general treatments
- Use of prescribed medications
- Performance of diagnostic procedures/tests and cultures
- Performance of other medically accepted laboratory test that may be considered medically necessary or advisable based on the judgment of my physician or their assigned designees.

I fully understand that this consent is given in advance of any specific diagnosis or treatment.

I intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended. The consent will remain in full force until revoked in writing *(see revocation section below.)*

I understand that **Neurosurgical Specialists of North Florida** may include consent at other satellite offices under common ownership.

A photocopy of this consent shall be considered as valid as the original.

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

_____ _____

Patient (or responsible party) Signature Date

Revocation

_____*I hereby revoke my general consent to treat at Neurosurgical Specialists of North Florida*

_____ _____

Revocation Signature (or representative) *Date*