GA–PCOM

Georgia Osteopathic Care Center

Authorization to Treat

I authorize to receive medical care and treatment as may be deemed necessary and advisable in the judgement of my physician or other medical provider for the conditions for which I present myself to this office. This may include, but not be limited to, history and physical examination, laboratory and radiology studies, Osteopathic Manipulative Therapy, and medical or surgical treatment or procedure.

I understand that this authorization will be valid and remain in effect as long as I receive my medical care at the Georgia Osteopathic Care Center. I understand that this authorization may be revoked in writing at any time.

_____

Patient or patient's representative (please print name)

_____ _____

Signature of patient or patient's representative *Date*

_____

Representative's relationship to patient