Mt. West Family Health Center

V.M. Villalobos, M.D. • Board Certified Family Physician

PLEASE PRINT!

Patient's Full Legal Name: ____
SS#: ____ DOB: ________________

- I hereby voluntarily consent to outpatient care at the office of V.M. Villalobos, M.D., encompassing routine diagnostic procedures, examination and medical treatment, including (but **not** limited to) routine laboratory work(i.e. blood, urine, etc.), taking of x-ray, heart tracing, and administration of medications prescribed by the physician.

- I further consent to the performance of those diagnostic procedures, examination, and rendering of medical treatment by the medical staff, their assistants, including physician assistants, family nurse practitioners, or their designees as is necessary in the medical staffs' judgment.

- RELEASE OF INFORMATION: I authorize the clinic to release medical information to third party insurance claims related to my medical care. I further authorize the release of medical information about treatment here to my physician or any designated by me.

- I understand that this consent form will be valid and remain in effect as long as I attend the offices of V.M. Villalobos, M.D.

- If the patient is unable to consent for treatment, I certify that I am the legal guardian for the patient and that I have complete authority to sign the consent form.

- This form has been fully explained to me, and I understand its contents.

____ ________________________
Signature of Patient or Person Authorized to Consent for Patient — Date