VIC
VASCULAR INSTITUTE
Chattanooga | Cleveland
North Georgia | Jasper | Dayton

Consent for Treatment

By signing below I give permission for physicians, Nurse Practitioners, associates, assistants, and other qualified medical personnel employed by Vascular Institute of Chattanooga's to give me medical treatment and to recommend and/or order diagnostic imaging or lab tests as indicated for evaluation of my medical condition.

I understand:

- I have the right to refuse any procedure or treatment.
- I have the right to discuss all medical treatments with my clinician.

This consent will remain valid unless and until it is revoked by the patient or their personal representative.

_____ _____

Signature of Patient
or Patient's Personal Representative

Date

_____ _____

Printed Name of Patient
or Patient's Personal Representative

Relationship to Patient

_____ _____

Signature of Witness

Date

_____

Printed Name of Witness