

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