Informed Consent for Facility Healthcare Provider Services

Resident's Full Name:
_____

Date of Birth: _____ Date: _____

I, the undersigned resident of [Facility Name], hereby provide my informed consent for the facility's designated healthcare provider to render medical services to me during my stay at the facility.

I understand and acknowledge the following:

Nature of Services: I am aware that the facility's healthcare provider offers medical services within the facility premises, which may include but are not limited to routine check-ups, medical consultations, and treatments as deemed necessary by the healthcare provider.

Voluntary Participation: I am not obligated to receive medical services from the facility's healthcare provider. I retain the right to choose an external healthcare provider at any time and for any reason.

Benefits and Risks: I have been informed of the potential benefits and risks associated with receiving medical care from the facility's designated healthcare provider. I understand that the facility's healthcare provider is familiar with the facility's operations and may offer convenient access to medical services.

ALEBOSS

Communication: I understand that the facility's healthcare provider will communicate with me about my medical needs, treatment options, and any recommended interventions. I am encouraged to ask questions and seek clarification regarding my medical care.

Confidentiality: I acknowledge that my medical information will be treated with confidentiality, adhering to applicable privacy laws and regulations. Information will be shared only with authorized personnel involved in my care.

Right to Decline: I have the right to decline or discontinue medical services from the facility's healthcare provider at any time. My decision will not affect the quality of care or services provided by the facility.

I hereby grant permission for the facility's healthcare provider to provide medical services as necessary and appropriate during my stay at [Facility Name].

Resident's Signature: _____ Date: _____

Witness's Signature (if required by facility policy): _____ Date: _____

Facility Representative's Signature: _____ Date: _____
(To be signed only if witness is not required)

Please retain a copy of this informed consent form for your records.

ALFBOSS