MEMORIAL NEUROLOGICAL ASSOCIATION
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PATIENT #_____

CONSENT FOR TREATMENT

I, _____authorize and direct Memorial Neurological
(patient's name)

Association and _____to perform upon me general and
(name of physician

neurological exams and/or any other procedure in his/her judgment determined advisable for my well being.

I acknowledge that the practice of medicine is not an exact science and that no guarantees have been made as to the outcome of procedures and/or treatment.

Patient
Signature_____Date_____

Witness_____Date_____

IF PATIENT IS A MINOR OR UNABLE TO SIGN:

Signature of
Responsible Party_____Date_____

Relationship to
Patient_____

Witness_____Date_____