CONSENT FOR TREATMENT

I understand that my care is under the supervision and control of my attending clinician, and I consent to all medical treatments, procedures, examinations and tests reasonably necessary for my proper care. I understand further that I have the right to more complete information concerning any particular diagnostic or therapeutic procedure and I may be asked for a more specific consent (verbal or written) to such procedures if the risk involved so indicates. I agree that aspects of my care and treatment may be recorded and/or filmed for internal organizational purposes, e.g. education. I recognize and acknowledge that all clinicians furnishing services to me, including, but not limited to, my attending clinicians, community clinicians, holding clinical privileges at this facility or clinic, and other clinicians such as those providing services to me in anesthesiology, radiology, pathology and emergency medicine, may be independent contractors and are not the employees or agents of Duke University Health System (DUHS; with the exception of residents engaged in graduate medical training and certain hospitalists employed by DUHS) or of each other while providing professional services, and I make this acknowledgment with the understanding that DUHS and the clinicians are providing services to me in express reliance on this written statement. I understand that no person has the authority to alter or amend this paragraph or any other paragraph in any manner.

I understand that the DUHS hospitals/clinics, Private Diagnostic Clinic, PLLC (PDC), Associated Health Services, Inc. (AHS) and Duke University Affiliated Physicians (DUAP) clinics are teaching facilities, and I agree that students training to be physicians, nurses and allied health personnel may assist and participate in providing my care and that my medical records may be used for purposes of research, education and patient care.

___________________________________________
STUDENT NAME

___________________________________________
PATIENT, PARENT, GUARDIAN OR AUTHORIZED REPRESENTATIVE

___________________________________________
WITNESS

______________________________
DUKE UNIQUE ID #

______________________________
DATE

______________________________
DATE

For internal use: this document must be scanned into Point & Click as document category “Consent to treat.”