Allison Win,M.D.,LLC.
2401 Research Blvd, STE# 102, Rockville MD 20850.
Phone: 240-224-7519 Fax: 240-224-7596
www.allisonwinmd.com

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General Consent for Treatment

I, _____ authorize and direct the office of Allison Win, MD to provide diagnostic, preventive and Therapeutic services which are deemed necessary for my health care.

_____ _____ _____

Date Signature Witness

Consent to Treatment of Minor/Incapacitated person

If the patient is a minor, or in any way incapacitated to sign him/herself, this form is to be completed for each such person and filed in that person's medical record.

Re: Patient's Name: _____, Date of Birth: _____,

A person incapable due to age or other incapacitation of making medical decisions for him/her.

I, the undersigned parent, legal guardian, or conservator of the patient identified above, authorize the following person, _____, to whom the patient has been entrusted, to act on my behalf to consent to any radiological examination, anesthetic, medical or surgical diagnosis or treatment and care which is advisable by, and is to be rendered under the general or special supervision of any licensed physician.

The authorization shall remain effective until _____, unless sooner

Month/Date /Year

revoked in writing and delivered to the office of ALLISON WIN, MD, LLC.

Date: _____ _____

Parent/legal Guardian/Health Care Designee Signature

Date: _____ _____

Witness's Signature and Title