THE UROLOGICAL CENTER

CONSENT FOR TREATMENT

Medical Power Of Attorney

Patient Name: _____

Date: _____

MEDICAL TREATMENT CONSENT

I _____ (patient name or legal POA) do hereby give consent to the providers at The Urological Center/Antietam UroSurgical Center for consultation and treatment including any procedures, on the above-named patient, that may be deemed necessary during this medical visit and future follow up appointments for a period of "one year" or until notification is received revoking this authorization.

***** Please provide a copy of the Medical Power of Attorney Document to our office to be included in the medical record of the patient. *****

_____ _____

Signature of Patients POA/Guardian **Relationship**

_____ _____

Witness **Date/Time**