Elisabeth Potter, MD, PLLC

Consent to Treatment

This consent covers all medical services rendered to me by Elisabeth Potter, MD, PLLC ("Practice"). The duration of this consent is indefinite and continues until revoked. I understand I may revoke this consent by informing the Practice in writing; but if I do revoke, it will not affect anything done prior to the date the revocation is received.

_____ **Consent for Treatment**: I have voluntarily presented to the Practice and consent to treatment of me by the Practice and its staff, including its physicians, physician assistants, nurse practitioners, and other employees, providers, and staff members. Such care may include, but is not limited to, general treatment, use of prescribed medications, performance of diagnostic procedures, test and cultures, and performance of other laboratory tests that my physician or his/her designee determines medically necessary or advisable based upon my condition. I acknowledge that no guarantee can be made or has been made as to the results of treatments or examinations and I understand that all medical treatments contain inherent risks. I understand that while my consent is voluntary, if I refuse to sign this consent, the Practice may refuse to treat me except in a case of emergency.

_____ **Consent for Photography**: I consent to have my image taken by the Practice and understand that my photographs, videotapes, digital, and other images will become part of my medical record and therefore protected, used and/or disclosed in accordance with the Practice's Notice of Privacy Practices. I understand that the Practice will own these images, but that I will be allowed to access or view them, or to obtain copies of them as part of my medical record.

Consent for Disclosure (optional): I consent to the additional use or disclosure of my images and/or medical information for the following purposes, and I hereby waive any right to compensation for such uses by reason of the foregoing authorization.

_____ Website marketing and online media

_____ News, media, and public relations

_____ Patient education & patient to patient communication

_____ **Minor/Disabled Patient**: I understand that if I am signing this consent on behalf of a patient who is under age 18 or impaired in such a way as to make him or her unable to consent to or refuse treatment, I represent to the Practice that I have the legal authority to consent to treatment on such patient's behalf. All references in the form to "I," "me," or "my" are intended as reference to such patient where appropriate in the context.

I acknowledge and agree that I have received this Consent to Treatment in its entirety and been given the opportunity to ask any questions. I acknowledge and agree that I have had all of my questions answered to my satisfaction.

Patient Signature (or authorized person) _____

Relationship to Patient _____ Date _____