Clear Sky Medical™
Wellgevity & Aesthetics
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Consent for Treatment Form

This form is to allow a family member or other person to have access to medical records, schedule visits, and refill prescriptions.

Patient Name: _____ (you)

Date of Birth: _____

List all persons who may act on your behalf for medical treatment including having access to your medical records:

Name:	Relationship to Patient:
_____	_____
_____	_____
_____	_____

_____

Signature of patient, parent or legal guardian

_____

Date