saltwater® MEDICAL
TRUST US TO CARE

MEDICAL CONSENT FORM

I, **(patient)** _____ give permission for_____

Relationship to patient_____

☐ to be responsible for scheduling my appointments at Saltwater Medical.

☐ I also give permission for scripts to be requested and/or collected by the person listed above until further notice.

☐ I also give permission for medical information to be discussed with the person listed above until further notice.

PATIENTS DETAILS

NAME:	
DATE OF BIRTH:	
PHONE NUMBER:	

Signature of patient _____ DATE__/__/____

Office use only

Scan to file ☐

update patient's file ☐

Completed by _____ DATE __/__/____