



## Consent to Treatment

I authorize Catherine's Health Center (Catherine's) and its medical, nursing, and other professional staff members to provide health care services. I authorize Catherine's professional staff members to administer such diagnostic and therapeutic procedures and treatments, as in the judgement of Catherine's medical personnel, is deemed necessary or advisable in my care.

I understand that all medical evaluation and treatment includes a degree of risk and i have the right to inquire about the risks and benefits associated with recommended testing and treatment.

Catherine's offers care in an integrated setting. Some health information is specially protected. I understand that I must give consent to share this information in some cases. This information includes HIV/AIDS status, sexually transmitted infections (STIs), tuberculosis (TB), Hepatitis B, genetic information, and behavioral health and substance use disorder information.

I understand that this Consent to Treatment will be valid for each visit I make to Catherine's until revoked to me in writing.

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Full Name of Patient

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Date

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Patient/Guardian Signature

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Date