AMERICAN LONGEVITY INSTITUTE

Patient Consent Form

Date _____

Full Name_____
No._____

Address_____ City_____
Zip_____

Phone _____ E-
mail:_____

I, (Patient) _____, wish to receive Hormone Replacement Therapy with (Doctor)_____ for the purpose of _____.

I hereby confirm my consent to treatment.

I confirm that I was provided in an understandable manner with health information, possible prognosis, risks and treatment methods most effective for me. I was provided with an opportunity to ask questions concerning the subsequent treatment and receive answers, which are clear to me.

I fully understand the purpose and nature of the subsequent treatment and therapeutic effect thereof. I give my consent to the proposed treatment plan.

I undertake to fulfill all physician's prescriptions and recommendations, which will be reflected in the corresponding medical records, and confirm the fact of my familiarization with such prescriptions and recommendations with my signature on the health records specified above.

I have read and understood this Consent Form and I give my consent to all the above by affixing my signature below.

_____ / _____
Signature of Patient/Other Responsible Person
Date

_____ / _____
Witness
Date