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CONSENT FOR HEALTH SERVICES

I, the undersigned, understand that I will be fully informed of the need, risks, and advantages of each medical procedure and treatment, and do hereby give my free and full consent to the Department of Public Health and Social Services to perform such necessary examinations and treatment deemed advisable in connection with my diagnosis and the maintenance of good health. I also understand that I have the right to refuse such care, unless required by law.

I, furthermore understand that it is my responsibility to supply accurate and complete medical history information to those involved with my care, and to inform them of any changes in my health. I also understand that it is my responsibility to inform those involved with my care if I do not understand any instructions given or cannot follow them.

This consent, unless sooner revoked in writing, shall expire upon my discharge by appropriate authorities of the Department of Public Health and Social Services.

WITNESS

NAME OF PATIENT (Print)

DATE

SIGNATURE OF PATIENT

SIGNATURE OF RESPONSIBLE PARTY
IF PATIENT UNDER 18 YEARS OLD

GUAM DPH&SS
RM#5 - 3/85