



**Consent For Treatment**

I hereby give consent for the staff of Peak Vista Community Health Centers to administer such medications, immunizations, and local anesthetics and to perform such procedures as may be necessary for proper health.

I assign medical/dental benefits, otherwise payable to me, from any group and/or individual health insurance policies, and authorize payment directly to the Peak Vista Community Health Centers for professional service rendered by them. I understand I am financially responsible for charges incurred in the course of treatment not covered or paid by my insurance company. I hereby authorize Peak Vista Community Health Centers to release to my insurance company any information requested in relation to health services.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date