Grace Medical Services, LLC

Agatha Ukaegbu, CRNP-BC, PMHNP-BC

6600 YORK ROAD, SUITE 200 • BALTIMORE, MD 21212

Phone: 443-275-1031

Consent for Treatment

Patient's name: _____

Address: _____ Telephone: _____

If patient is a child, please complete following information:

Mother or father's name: _____

Address: _____ Telephone: _____

I hereby consent to the telephone provision of care, diagnosis and/or treatment by Grace Medical Services 6600 York Rd., Suite 200B, Baltimore, MD 21212, and I hereby acknowledge that such consent will remain in effect and until I cancel such consent in writing

I hereby acknowledge and confirm that I am mentally capable of giving informed consent to the provision of the care, diagnosis and/or treatment and am not subject to duress or under undue influence.

_____ _____

Signature of patient or person authorized to consent: **Date:**

_____

Relationship if not patient: _____

*If this consent is signed by someone other than the patient, it must be signed in the patient's presence.