



DERMATOLOGY • DERMATOPATHOLOGY • MOHS MICROGRAPHIC SURGERY • PLASTIC SURGERY & AESTHETICS

Consent to Medical Care

In presenting the patient for examination and treatment at Vanguard Medical Specialists, LLC (Vanguard):

Patient's name is: _____ Patient's DOB: _____

My Name is: _____ My DOB: _____

I am the power of attorney, and I hereby declare that I have the right to grant this consent to Vanguard, understanding that Vanguard will rely on this consent with regard to the examination and treatment of the patient. I hereby release Vanguard from any liability relating to the acceptance of this consent.

I voluntarily consent to the medical examination and treatment, and procedures recommended by the patient's medical provider at Vanguard. I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment on the patient's condition.

I give my full permission and consent to:

Name Relationship Daytime Phone Number

Name Relationship Daytime Phone Number

who is/are caring for the patient, as temporary guardian, for the period: _____ until _____ to:

- Direct medical examinations and treatment for the patient, whether routine or in an emergency;
- Sign any documents, consents, waivers or releases from liability, or authorizations needed in connection with any examinations and treatment for the patient; and
- Obtain and have access to the patient's medical or health records, files, and related information, whether privileged or not, for any purpose in connection with the foregoing.

In connection with routine care, or as soon as reasonable *after proper emergency care has been provided to the patient*, Vanguard may make reasonable attempts to contact me in the following manner:

Name Daytime Phone number(s)

I acknowledge that the patient is still responsible for all medical charges in connection with care and treatment rendered to him or her. This consent is governed by the laws of the State of Colorado. **Signing of the consent is acceptance of all terms as they are written. No amendments or modifications will be granted.**

I have read this form and certify that I understand its contents.

Power of Attorney Signature Date

BRIARGATE • BROADMOOR • PUEBLO • WOODLAND PARK

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