NONA MEDICAL ARTS

Multidisciplinary Pain Management & Regenerative Medicine

PATIENT AUTHORIZATION

I, _____hereby provide my consent to the
(patient name)

presence of the observer(s) at Lake Nona Medical Arts during my

_____
(name of medical procedure)

on _____.
(date)

I understand my participation is voluntary and that I am not required to sign this consent form in order to receive treatment or for payment of my care. I may revoke this consent at any time before or during the procedure.

Signature: _____ Date: _____
(patient or legal representative)

Print Name: _____

Witness: _____ Date: _____