WESTCHESTER INSTITUTE FOR HUMAN DEVELOPMENT **Cedarwood Hall** **Valhalla, NY 10595-1689**	**NAME** _____ **D.O.B.** _____ **WMC #** _____ **WIHD#** _____ *(For WIHD Use Only)*
CONSENT FOR CARE AND TREATMENT	

1. I hereby authorize _____ to participate in out-patient care and treatment at the Westchester Institute for Human Development, and the physicians, dentists, allied health professionals on its staff, nursing staff, and paramedical staff, assisted by the employees of the Institute, to provide such medical or dental care and to administer such routine diagnostic tests and procedures, including but not limited to, diagnostic x-rays; the administration and/or injection of pharmaceutical products and medications, including but not limited to sedatives, influenza and hepatitis vaccines and antibiotics, when indicated; and the drawing of blood, as in the judgment of the above Institute's personnel and/or attending physician(s) is deemed necessary.

   I acknowledge that no guarantees or assurances have been made to me concerning the results or findings intended from the treatment(s) or examination(s) at the Westchester Institute for Human Development.

2. I confirm that I have read and fully understand the above, and have been given the opportunity to ask questions, and that all my questions have been answered fully and to my satisfaction. I have deleted and initialed procedures for which I withhold permission.

Patient/Relative or Guardian*

_____ _____
Signature of Patient or Personal Representative | Print Name of Patient or Personal Representative

_____ _____
Date | Description of Personal Representative's Authority

Interpreter (if required)

_____ _____
Signature | Print Name

***Patient must sign unless he/she is unemancipated minor under the age of 18 or lacks the capacity to understand what is being signed.**

THIS DOCUMENT MUST BE MADE PART OF THE PATIENT'S MEDICAL RECORD.