

# PCOM Healthcare Centers

## Authorization to Treat

I authorize to receive medical care and treatment as may be deemed necessary and advisable in the judgment of my physician or other medical provider for the conditions for which I present myself to this office. This may include, but not be limited to, history and physical examination, laboratory and radiology studies, Osteopathic Manipulative Therapy, and medical or surgical treatment or procedures.

I understand that this authorization will be valid and remain in effect as long as I receive my medical care at the PCOM Healthcare Center. I understand that this authorization may be revoked in writing at any time.

---

Patient or Patient's Representative (Please print name)

---

Signature of Patient or Patient's Representative

---

Date

---

Representative's Relationship to Patient