MN ANGELS CLINIC
Dr. GEORGES T. JABALY
4405 HOLLAND SYLVANIA RD., STE.104 TOLEDO, OH 43623

PATIENT'S NAME:_____

CONSENT TO MEDICAL AND/OR SURGICAL TREATMENT

I, the undersigned, consent to authorize any diagnostic, therapeutic and surgical procedures as ordered and deemed necessary by my physician. I also indemnify and hold harmless Dr. _____ by reason of claim that might be made as a result of any alleged lack of consent.

ADVANCED DIRECTIVE

I am aware that as an adult in the stat of Ohio, I have the right to make advanced directives, such as a **Durable Power of Attorney** for health care and /or a **Living Will.**

Do you have a Living Will?

Yes_____ NO_____

Do you have a Durable power of Attorney?

Yes_____ NO_____

Are they already on file here?

Yes_____ NO_____

_____

Patient signature Date