

# CONSENT FORM

## CONSENT FOR SUBSTITUTE PHYSICIAN

Although I have engaged Dr. \_\_\_\_\_ to provide medical care and attention for \_\_\_\_\_, I fully understand that the necessities of the practice or personal life may not allow the doctor to be available at all times. With this understanding, I authorize:

- (a) My physician's associates, including Drs. \_\_\_\_\_, \_\_\_\_\_ to render care in his/her place.
- (b) Dr. \_\_\_\_\_ to refer me to a qualified physician to render care in his/her place.

I agree to hold Dr. \_\_\_\_\_, his/her associates, employees, and agents free of any responsibility and hold them harmless for not attending \_\_\_\_\_ for any reason and instead referring \_\_\_\_\_ for care as indicated above.

\_\_\_\_\_  
(Patient or patient's authorized representative)

Witness: \_\_\_\_\_

Date: \_\_\_\_\_