CONSENT TO USE PHYSICIAN'S ASSISTANT/NURSE PRACTITIONER

I, ____, hereby authorize my physician

____ to instruct his/her Physician's
Name of Physician

Assistant or Nurse Practitioner to assist him/her in certain aspects of my medical care. I understand that a Physician's Assistant or Nurse Practitioner is not a licensed physician and may diagnose and treat an illness, injury, or medical condition only under the supervision and direction of a medical physician. I further understand that I may revoke this authorization at any time and that, at any time, I may request to be seen by my physician.

_____________________________________   _______________________
Signed   Date

_____________________________________   _______________________
Witness   Date