



INFORMED CONSENT RELEASE

I, _____, voluntarily consent to medical treatment and lab tests as
(Print patient full name)
recommended by BluMine Health. The care provided does not come with any guarantees and I may
change providers or chose to seek treatment elsewhere whenever I deem it in my best interests. I
acknowledge and have been informed of risks and benefits of various means of receiving medical
treatment. I am fully capable of making medical decisions for myself or may delegate a family member
to do so if I am unable.

X _____
Patient/Parent/Legal Guardian Signature
Digitally signed

Date: _____

If Patient is a Minor (under 18):

Print Name Parent/Guardian: _____

Relationship to Minor: _____