

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