Mayfair Internal Medicine, P.C.
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INFORMED CONSENT FOR TREATMENT DURING COVID-19

CONSENT:

I, (print name) ____, knowingly and willingly consent to medical treatment at Mayfair Internal Medicine. I understand that the COVID-19 virus has both asymptomatic carriers and a long incubation period. It is impossible to determine who might be an asymptomatic carrier of COVID-19.

Mayfair Internal Medicine has taken many steps to lower the risk of respiratory infection for the safety of patients and staff. However, I understand that, due to the number of patients visiting Mayfair Internal Medicine and the characteristics of the virus, I am at risk of contracting the virus and I am consenting to medical treatment.

Patient signature: _____________________________Date: _________

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