

## **AUTHORIZATION FOR TREATMENT**

I voluntarily consent to healthcare treatment from the physician and staff at Alzheimer's Memory Center. I also consent to any necessary lab work.

Dr. Bolouri does not have an inpatient service at any hospital. The inpatient physicians will care for you if such treatment is needed. We will see you after your discharge from the hospital.

**Signature** \_\_\_\_\_ **Date** \_\_\_\_\_