

# FAIRFIELD

## Institute of Management & Technology

### CONSENT FOR TREATMENT

In the event that my child/dependent, \_\_\_\_\_,  
Print Name Birth date

reports to the Rural Community Health-Care and Diagnostic Center at FIMT for medical care, I do hereby consent to such clinic care, including diagnostic procedures and medical treatment deemed appropriate by the Health Center medical staff.

I also authorize FIMT to release health and accident information to any physician, hospital, or other medically – related facility involved in my child’s/dependent’s treatment.

If my child/dependent does not have finances at the time of his/her visit to the Rural Community Health-care & Diagnostic Center, I agree to be responsible for the payment of any services rendered by the Health Center staff on behalf of my child/dependent.

\_\_\_\_\_  
Signature of Parent/Guardian Date

Rural Community Health-care & Diagnostic Center  
RZ-A-44, Mahipalpur, New Delhi-110037