Texas Health Care, P.L.L.C.
923 Pennsylvania Ave., Suite 100
Fort Worth, Texas 76104

CONSENT TO TREAT A MINOR

This consent has been prepared according to guidelines presented by the Texas Family Code (Section 35.01). All information must be completed fully on this form. (Please print).

Minor's Full Name _____

The name of one or both parents, if known, and the name of the managing conservator or guardian if either has been appointed:

The name of the person giving consent and his/her relationship to the minor: _____

A statement describing the medical treatment for which consent is to be given:

The following persons may consent to a minor's medical treatment when the person having the power to consent cannot be contacted and when the absent person has not indicated a refusal to consent. Please indicate the appropriate situation as to who will be signing the consent.

___A Grandparent, ___An adult brother or sister, ___An aunt or uncle, ___An educational institution in which the minor is enrolled, if the person who has the power to consent has given the institution prior written authorization to do so, ___any adult who has care and control of the minor, if the child's parent or guardian has given prior authority to consent, ___any court having jurisdiction of the child.

_____
Signature of Consenting Adult

PHONE CONSENT

When consent to treat the above minor was not possible, consent to treat was provided over the telephone by:

_____

Whose relationship to the minor is as follows: _____

_____
Signature and title of office staff

TEXAS HEALTH CARE, P.L.L.C.
923 PENNSYLVANIA AVE., SUITE 100
FORT WORTH, TEXAS 76104

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician(s) and/or order another person to perfrom all exams, tests, procedures, injections, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. This consent is valid for each visit I make to Dr. _____ , with Texas Health Care, P.L.L.C. unless revoked by me in writing.

_____ _____
Date Patient/Legal Representative

_____
Signature and title of office staff