

Family Medical Center

at

Cinco Ranch

23144 Westheimer Parkway * Katy, TX 77494 * Office 281.392.5005 * Fax 281.392.5052

AUTHORIZATION FOR TREATMENT OF A MINOR

Minor's Name in Full

____/____/_____
Date of Birth

I/we, the undersigned parent(s)/legal guardian(s), of the minor person listed above do authorize the physicians of Family Medical Center at Cinco Ranch to provide health services to this minor in the absence of a parent or legal guardian. This health service may include, but is not limited to: examination, preventative and/or curative treatment, x-ray, laboratory examination, anesthetic, medical or surgical diagnosis, and any consultation deemed necessary at the physician's discretion. Services shall not include research or experimentation.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required and is given to encourage the physician to exercise his or her best judgement as to the requirements of such diagnosis or medical treatment in my/our absence.

NOTE: Not used as permission for vaccines.

This consent shall remain in effect until revoked, in writing, by parent(s) or legal guardian(s) or until child may legally consent for him or herself.

Signature - Parent or Legal Guardian

Date

Print Name and Relationship

Signature - Parent or Legal Guardian

Date

Print Name and Relationship