**Whitestone Pediatrics**

**&**

**Liberty Hill Pediatrics**

***CONSENT TO TREAT***

*Please read carefully*

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_**

**CONSENT FOR TREATMENT**

I hereby authorized evaluation and treatment by the providers and staff associated with Whitestone Pediatrics and Liberty Hill Pediatrics. I understand and agree that the signatures and dates on this form will not expire without written notice or in the case that a minor becomes of age at 18, and that a photocopy of this form is considered valid as the original.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian (Please Print) / Relationship

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian (Signature) Date

**CONSENT TO TREAT PATIENT (UNDER AGE OF 18)**

**WITHOUT PARENT PRESENT**

I hereby authorize **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** to bring my child to his/her

***Name/Relationship***

appointments if I am unable to attend. I understand that medical advice will be relayed to them on my behalf.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian (Please Print) / Relationship Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Legal Guardian (Signature) Date