Associated Women's Healthcare, LLP

Obstetrics, Gynecology & Infertility

CONSENT TO TREATMENT OF A MINOR

This form is to be completed for each minor and filed in the minor's chart.

DATE: _____

TO: Associated Women's Healthcare, LLP
Associated, Nurses and Staff Members
1600 Coit Rd., Suite 402
Plano, Texas 75075

RE: _____, a minor.

DATE OF BIRTH: _____

I, _____ parent(s) or legal guardian(s) of _____, a minor, consent to, and hereby authorize Dr. _____, to treat and provide medical care to said minor.

I am the person having the power to consent to medical treatment of said minor.

This consent shall remain effective until revoked in writing and delivered to Associated Women's Healthcare, LLP.

_____ _____
Printed Name of Parent or Legal Guardian Date

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Signature of Witness Date

consentofminor

Dawn Bankston-Troiani, M.D. ● Cindy C. Hartley, M.D. ● Aungel L. Evans, M.D.

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