Consent for Medical Treatment of a Minor/Patient

Name of Minor/Patient: _____

Date of Birth: _____

Name of Person Giving Consent: _____

I am the (check one) of the Minor/Patient named above:

___ Parent ___ Managing Conservator ___ Guardian

I give permission for Plano Wellness, PLLC to provide confidential medical evaluation and treatment to the minor named above. I understand the care being rendered may include diagnostic testing, in office labs, surgical evaluation and contraceptive services. Additional diagnostic testing may be sent or requested from a third-party testing facility.

It is understood this authorization is given in advance of any specific diagnosis, treatment or care being required. It provides authority and power to render care to above-mentioned by Marlene Diaz, MD and the staff of Plano Wellness in the exercise of their best judgment.

I agree to accept financial responsibility for all care and services delivered pursuant to this authorization. This authorization also grants the power to release information to any third-party payors who may be responsible for part or all the cost of the services provided.

I declare under penalty of perjury that the above information is true and correct.

My signature signifies that I have read and understand the content of this consent.

Signature of Person Giving Consent:

Signature: _____ Date: _____

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