5100 W Hwy 290, Bldg 2, Ste 110
Austin, TX 78735
512-454-0406
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THE Minor Consent to Treat - Parental Preauthorization

MINOR CONSENT TO TREATMENT

Patient Name: _____ Date of Birth: _____

General Consent

I authorize Austex Pediatrics and staff to perform or prescribe any reasonable and necessary medical examination, testing, and treatment that the physician determines advisable for my child's well-being.

Parental Pre-Authorization

In my absence, I request and authorize Austex Pediatrics and its staff to discuss my child's Personal Health Information and to deliver medical care, including immunizations, to my child when accompanied by the following individual(s):

FIRST NAME	LAST NAME	RELATIONSHIP	PHONE NUMBER

By leaving this blank I am stating I DO NOT authorize anyone other than the child's parent(s)/legal guardian(s) to accompany my child to Austex Pediatrics for provision of medical services.

Note: If any special parental or custodial relationships exist that apply restrictions/limitations, we may request a copy of court documentation to be placed in the patient's chart.

Name: _____ Relationship: _____