CONSENT TO TREAT A MINOR BY ZOLTAN TRIZNA MD, PA

This consent has been prepared according to guidelines presented by the Texas Family Code (Section 32.01) All information must be completed on this form.

Minor's full name _____ Date of birth: _____ / _____ / _____
First Name Last Name

The name of the person giving consent and his/her relationship to the minor:

_____

A statement describing the medical treatment for which consent is given:

_____

(If this consent is for today and future medical care, please indicate "all medical treatment")

The date the treatment is to begin: _____ / _____ / 20____

The date this consent ends: _____
(Please specify date span or write "indefinitely")

The following persons may consent to a minor's medical treatment when the person having the power to consent cannot be contacted and when the absent person has not indicated a refusal to consent.

A grandparent; an adult sibling; an adult aunt or uncle; an educational institution in which the minor is enrolled, if the person who has power to consent has given the institution prior written authorization to do so. Any officer of peace who has justification for seeking medical care for a minor in their custody. Any court having jurisdiction of the minor. Any adult who is the legal representative for the minor patient.

Check applicable box

☐ **The minor above may be seen and treated in the office without parent or guardian present.**

☐ **The minor above may be seen and treated in the office when accompanied by:**

Name _____ **Relationship to minor:** _____

Signature of Custodial Parent or Guardian or as indicated above

_____ Date: _____/_____/_____

☐ **Written consent to treat the above minor was not possible. Consent to treat minor was provided over the telephone. Name and relationship to minor of the person giving consent:**

_____

_____ Date: _____/_____/_____
WITNESS
Zoltan Trizna MD, PA Staff