**Melody Cassels, M.D.  
Wesley Glazener, M.D.   
Kendall Burns, D.O.**

**MINOR CONSENT TO TREATMENT**

Patient Name **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date Of Birth**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** (FIRST) (LAST) (MONTH-DAY-YEAR)

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.

Signature of Parent/Guardian

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
(PRINTED NAME (DATE)  
  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
(SIGNATURE OF PARENT/GUARDIAN) (RELATIONSHIP)