Texas Health®

CONSENT TO TREAT

I hereby authorize employees and agents of Texas Health (including physicians, physician assistants, and nurse practitioners, and other employees and staff members) to render medical evaluations and care to the patient indicated below. I understand that in connection with the patient's treatment, photos or videos may be taken. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of emergency.

Today's Date: _____

Print Patient's Name: _____

Patient Date of Birth: _____

Legal Guardian: (if different than patient) _____

Patient or Legal Guardian Signature: _____

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