ALLERGY & ASTHMA
CENTER OF TEXAS

Consent to Treat

I hereby authorize Allergy & Asthma Center of Texas and its employees and agents, including physicians, physician assistants, medical assistants and nurse practitioners to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians, including consultants, associates, and assistants of the physicians' choice.

_____
Patient Name DOB

_____
Signature (Responsible Party) Date

If patient is a minor, and you want to designate another party to accompany patient to office visit, allergy injection, procedure, etc., please complete section below:

I consent and authorize _____ to also consent to and authorize evaluation and treatment for my child_____ when I am not available. I understand that this authorizes the person(s) named above to consent to medical and surgical procedures for the child named herein. The duration of this consent is indefinite and continues until revoked in writing.

_____
Signature Date