

Hill Country Medical Associates
774 Landa Street
New Braunfels, TX 78130
(830) 625-0305

Consent for Treatment of Minor*

I hereby consent for my son/daughter, _____, date of
Print First and Last Name

birth ____/____/_____, to be seen and treated by _____
Print Provider's Name

on ____/____/_____. I can be contacted at (____) _____ if necessary.

Print First and Last Name

Relationship to Minor

Signature

Date

Verified via Driver's License/Social Security Number _____
Please provide a copy of parent/guardian Driver's License with form if not presented in person

Consent provided via phone conversation

Signature of Staff Member Verifying Consent

Print Name of Staff Member

* Consent for Treatment of Minors (children under 18 years of age) is required by Section 32 of the Texas Family Code.