

West Texas A&M University
Student Medical Services
Consent To Treatment

Date _____ -

1. I, _____ ,
 (Name of person giving consent)
(the) _____
 (relationship to patient)
of _____

(Name of Patient)

SS # of Patient _____

hereby voluntarily consent to outpatient care encompassing routine diagnostic procedures, examinations, and medical treatment. This may include (but is not limited to) routine laboratory work, x-rays, EKG's, administration of medications, inpatient and emergency care as needed.

2. I further consent to the performance of those diagnostic procedures, examinations, and the rendering of medical treatment by the office staff and their assistance as directed by the provider.

3. I authorize Student Medical Services to release medical information to third party insurance carriers for the purposes of filing insurance claims related to his/her medical care. I authorize Student Medical services to release any medical information to other physicians or medical providers as directed by the Student Medical Services Department. I authorize the release of medical information about his/her treatment to any other physician, provider or facility designated by me.

4. I understand that this consent form will remain in effect as long as the patient is a minor.

5 This form has been fully explained to me and I understand its contents.

Comments: _____

Patient is a Minor, _____years of age.

Date of birth_____

Signature of Legal Guardian

Witness