

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