PRIVIA MEDICAL GROUP NORTH TEXAS

CONSENT FOR TREATMENT

By signing this consent, I _____, parent or guardian of (patient's name) _____, a minor, do hereby authorize the ***Following Name(s):***
(Example: Dad, Mom, name of friend, grandparents, aunt, uncle, neighbor, etc.)

a. _____

b. _____

c. _____

as my agent(s), authorizing my physician(s) and/or order another person to perform all exams, tests, procedures, injections, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of their medical condition. This consent is valid for each visit I make to Dr. _____ with Privia Medical Group North Texas unless revoked by me in writing.

_____ _____

Print Patient Name Patient Birthdate

_____ _____

Date Patient/Legal Representative