PEDIATRIC UROLOGY
OF HOUSTON

Patient Consent to Treat

Name of patient:_____

I have the legal right to consent to medical treatment because (a) I am the patient, or (b) I am the parent/guardian of the patient. All references to "patient" or "my" in this document refer to the patient above.

I voluntarily authorize and consent to the medical care, treatment, and diagnostic tests at Houston Pediatric Urology and their designated associates or assistants believe are necessary for the patient. I consent to the taking of photographs, diagnostic images and films related to the care and treatment of the patient. I understand that by signing this form, I am giving permission to the doctors, medical assistants and other health care providers at Houston Pediatric Urology to provide treatment as long as a physician and patient relationship exists, unless withdraw my consent.

By signing below I acknowledge that I have read and understand the contents of this form, and that I have had an opportunity to discuss my or my child's care with a health care provider at Houston Pediatric Urology. I have asked all my questions and concerns answered about this form by a member of Houston Pediatric Urology.

If you have any questions please call us at (713) 701-9451.

Patient's Name _____

Patient's Date of Birth _____

Patient's Representatives Name_____

Relationship to the Patient_____

Patient's representative's Signature _____

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Date of Signature _____