Complete Women's Wellness
GYNECOLOGY

Consent for Treatment of a Dependent Minor

Patient Name:______________________________D.O.B.______________Age:________

Address:____________________________________City:________________State:______Zip:_________

Name of Parent or Legal Guardian:____

Address:____

Home #:_______________________________Cell#:______________________________

I hereby authorize (circle provider/s) Dr.Melissa Wampler; Annaliesa Wallace, PA-C; Nancy Morris, WHNP, Niessa Meier, CNM, to render medical or surgical treatment to my dependent minor.

This permit is valid for one year from the date of signature.

Nature of Medical Treatment to be given and date given:

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_______________________________________ _______________________________
Signature of person granting consent Relationship to minor

_______________________________________ _______________________________
Print Name Date Time

____
Witness

708 Hill Country Drive, Suite 300A, Kerrville, Texas 78028
Ph: (830) 895-7755 Fax: (830) 896-4309

Consent for Treatment of a non-Dependent Minor

Patient
Name:____D.O.B.:______________Age:_________
Under Texas Law, a minor (under age 18) CAN GIVE CONSENT FOR EXAMINATION AND TREATMENT AND CAN CONTROL RELEASE OF THEIR MEDICAL RECORD only if:

- They are on active duty with the military
- They are married
- They are 16 or older and living apart from parents & manage their own financial affairs
- They are being treated for infections, contagious, or communicable diseases reportable to TDH
- They are unmarried and pregnant
- They are being treated for sexual abuse, suicide prevention, physical abuse, or chemical addiction/dependency

I hereby declare that one of the above situations applies to me and I can legally consent for my own treatment.

______________________________________ ______________________________________
Signature Date

____
Witness

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