Permission to Treat a Minor

Date _____________

The completion of this form will certify that I, __________________________________
(Name of Parent or Legal Guardian)
give permission for the providers of Woodlands OB GYN Associates, to provide medical treatment to my minor child, ____
(Full Name of Child)
including office consultation, physical exam, lab work and any medical treatment deemed necessary by the physicians.

This may also include the following: (Please Initial)

_________ Discussion of contraception and birth control.
_________ Prescription of birth control.
_________ Discussion of STD's, sex and any related issues.

This permission will remain in force unless I give written notice that it is void. In addition, I realize that there will be a charge for these services and agree to accept responsibility for payment of such services.

Date ______________

____
Signature of Parent or Guardian

____
Address

____
City, State, Zip Code

____
Telephone