12822 Veterans Memorial Drive
Houston, TX 77014
Tele: 832-779-3330
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RainbowPediatricsHouston.com

Consent to Treatment Authorization of Minor

Today's Date: _____/______/_______

Patient Name ____

Date of Birth ______/______/______

Parent/Legal Guardian's Printed name ____

I hereby give consent to Rainbow Pediatrics of Houston, PLLC and/or its employees to perform any examination, lab testing, vaccination, medical diagnosis or treatment as deemed advisable.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or medical care being required.

This consent is given to any and all such diagnoses, treatments and medical care which a licensed physician at Rainbow Pediatrics of Houston, PLLC recommends.

This authorization will remain in effect until revoked in writing by the parent or legal guardian.

Signed: _____________________________________ Print Name: _______________________________

Date: ____/_____/_____ Relationship to Patient: _______________________________________