HALLSVILLE
MEDICAL CLINIC

Consent to treat a minor

I, _____, the legal parent/guardian of _____ with date of birth _____, give consent for my child to be treated at the Hallsville Medical Clinic in my absence.

I agree to send payment with my child on the day of the visit, otherwise I authorize Hallsville Medical Clinic to use the credit card on file for services rendered.

_____ Date _____

Signature of parent/guardian

_____ Date _____

Witness

Jean Rene' Yates-Halbert, PA-C
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