



James E. Williams
3103 SE Military Drive Suite 105
San Antonio, Texas 78232
210-298-4711 Fax 210-298-4717

CONSENT TO TREATMENT

Patient Name: _____ **Date:** _____

1. I, _____ (the _____ of _____),
(Name of person giving consent) (Relationship, if other than patient) (Person to be treated)

Hereby voluntarily consent to outpatient care at Cedar Hills Family Practice encompassing routine diagnostic procedures, examination and medical treatment including (but not limited to) routine laboratory work (such as blood, urine and other studies), taking of X-ray, heart tracing and administration of medications prescribed by the physician.

2. I further consent to the performance of those diagnostic procedures, examinations and rendering of medical treatment by the medical staff, their assistants including physicians' assistants or their designees as is necessary in the medical staff's judgment.

3. **RELEASE OF INFORMATION:** (a) I authorize the clinic to release medical information to third party insurance carriers for the purposes of filing insurance claims related to my (his/her) medical care; (b) I further authorize the release of medical information about treatment here to my (his/her) doctor or anyone designated by me.

4. I understand that this consent form will be valid and remain in effect as long as I (he/she) attend the clinic.

5. This form has been fully explained to me and I understand its contents.

COMMENTS:

Signature of Patient or Person Authorized to
consent for patient

Signature of witness who explained the
contents of this consent form

If patient is a minor or is unable to consent, complete the following:

A. Patient is a minor _____ years of age.

Name of Father _____ Name of
Mother _____

B. Patient is unable to consent
because _____

Signature of Closest Relative or
Legal guardian

Relationship

Witness to representative' signature