Greg Krenek, M.D., P.A.
503 Medical Center Blvd, Suite 140
Conroe, TX 77304
936-756-0668

Consent for Medical Treatment for Minors

I hereby authorize Dr. Greg Krenek/Sally Ann Shaver NP to provide medical treatment for my son/daughter.

Name of Minor:____

Date of Birth (month/day/year):__________________________________

Through date of 18th birthday

Name of Parent/Guardian:______________________________________

Relationship:______________________________

Address of Parent/Guardian:_____________________________________

____

Primary contact no. of Parent/Guardian:_____________________________

_________________________ Date

__________________________________ Signature