



Round Rock OBGYN, PA

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Consent to Treat Minors

Date: _____

I certify that I am the legal guardian of the minor listed below. I give Round Rock OBGYN, PA and its employees permission to evaluate, diagnose and treat this individual even if I am not present.

Guardian's printed name: _____

Relationship to minor: _____

Minor's full name: _____

Minor's birth date: _____

Phone number: _____

Address: _____

Signature of legal guardian