

The Hand Center of San Antonio
9150 Huebner Road, Suite 290
San Antonio, Texas 78240

Letter of Medical Consent

Patient Name: _____

DOB: _____

Parent/Guardian: _____

Accompanying Guardian: _____

Date of Appt.: _____

Treating Physician: _____

I give the above named individual (noted as: accompanying guardian) my permission to give medical consent to any medical treatment requested by the physician for my minor child.

Signature of Parent/Guardian

Date