

The Hand Center of San Antonio
21 Spurs Lane, Suite 310
San Antonio, TX 78240
210-558-7025 phone
210-558-4664 fax

Letter of Medical Consent

Patient Name: _____

DOB: _____

Parent/Guardian: _____

Accompanying Guardian: _____

Date of Appointment: _____

Treating Physician: _____

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

Signature of Parent/Guardian

Date