

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 to provide medical treatment for my son/daughter.

Name of Minor: _____

Birthdate (date/month/year): _____

Through date of 18th Birthday: _____

Name of Parent/Guardian: _____

Relationship: _____

Address of Parent/Guardian: _____

Telephone No. of Parent/Guardian: _____

Date

Signature
(Parent or legal guardian)