FAMILY MEDICINE

I, _____ give my permission for my child, _____, to be treated by
(parent or guardian's name) (child's full name)
any provider associated with HV Family Medicine, PLLC, located at 2300 Highland Village Road, Ste 600, Highland Village, Texas 75077.

Signature of Parent or Legal Guardian _____

Printed name of Parent or Legal Guardian _____

Address _____

_____

Home phone _____

Date _____