THOMAS A. DURNELL, MD

Womencare Associates

Dedicated to excellence in Women's Healthcare.

CONSENT TO TREAT MINOR PATIENT

I ____ am the legal parent/guardian of
(Please Print)

____, date of birth ________________
(Please Print)

who is currently a minor.

I authorize Thomas A. Durnell, MD, to provide medical care to my dependent, including but not limited to, diagnostic examination and medical treatment.

I understand that once my dependent reaches the age of maturity, my consent for treatment is no longer required.

By my signature, I acknowledge that I have read and understand this consent, and that any questions I have prior to signing this can be answered by calling the office at (304) 424-2088.

_______________________________________ ___________________
Parent/Guardian Signature Date

____
Emergency Contact Phone Number

****PLEASE PROVIDE COPY OF DRIVER'S LICENSE FOR PROOF OF IDENTITY****