KATHRYN E. WHITE, M.D.

Gynecology & Infertility

<u>CONSENT TO TREATMENT OF A MINOR</u>

This form is to be completed for each minor and filed in the minor's chart.

DATE: ______________________________

TO: Kathryn E. White, M.D.
Associates, Nurses and Staff Members
2840 Legacy Dr., Suite 200
Frisco, TX 75034

RE: ___________________________________, a minor.

DATE OF BIRTH: ___________________

I, _____________________________ parent(s) or legal guardian(s) of __________________________, a minor, consent to, and hereby authorize Dr. Kathryn E. White, to treat and provide medical care to said minor.

I am the person having the power to consent to medical treatment of said minor.

This consent shall remain effective until revoked in writing and delivered to Kathryn E. White, M.D.

____ ___________________________
Printed Name of Parent or Legal Guardian Date

____ ___________________________
Signature of Parent or Legal Guardian Date

____ ___________________________
Signature of Witness Date