Family Care Clinic
D. Blayne Laws, M.D.
717 W. Lampasas St.
Ennis, TX 75119

CONSENT FOR TREATMENT

Patient Name: ______________________________ Date: ______________________________

Address: ____

Telephone Number: _______________________ Date of Birth: __________________________

1. I, _________________________, (the____ of ____________________________) hereby voluntarily consent to outpatient care at the office of D. Blayne Laws, M.D., encompassing routine diagnostic procedures, examinations and medical treatment, including (but not limited to) routine laboratory work (such as blood, urine, and other studies), taking of x-rays, heart tracing, and administration of medications prescribed by the physician.

2. I further consent to the performance of those diagnostic procedures, examinations and Rendering of medical treatment by the medical staff, their assistants, including physician's Assistants or their designees as are necessary in the medical staff's judgment.

3. RELEASE OF INFORMATION: (A) I authorize the clinic to release medical information to third party insurance carriers for the purpose of filing insurance claims related to my (his/her) medical care. (B) I further authorize the release of medical information about medical treatment here to my (his/her) doctor or any designated by me.

4. I understand that this consent form will be valid and remain in effect as long as I (he/she) attend(s) the office of D. Blayne Laws, M.D.

5. This form has been fully explained to me, and I understand its contents.
Comments: ____

___________________________________	______________________________
Patient Signature or Signature of Individual Authorized to Sign for Patient	**Witness**