



Dr. Lara Varisco Leonhardt, MD

General Consent to Treat

I am the parent/ guardian of _____ (name of patient), I have the legal right to consent to medical and surgical treatment for this patient.

I voluntarily authorize and consent to such medical care, treatment, and diagnostic tests that Dr. Lara Leonhardt and his/her designated associates or assistants believe are necessary for this child. I understand that by signing this form, I am giving permission to the doctors, physician assistants, and other healthcare providers in this medical office to provide treatment to this child as long as this child is a patient in this office, or until I withdraw my consent.

I have read this form or this form has been read to me in a language that I understand, and I have had an opportunity to ask questions about it.

Delegation of Consent

I hereby authorize (when I am unavailable to give consent) the following individual(s) to consent to any and all medical care and attention for this child which is deemed necessary and appropriate by a healthcare provider licensed in the state of Texas. This consent includes, but is not limited to, medical and surgical intervention, and elective as well as emergency care. This delegation shall be valid until I withdraw delegation of consent.

Those Whom Consent is Delegated:

Name	Relation to Patient
_____	_____
_____	_____
_____	_____

Signature of Parent/ Guardian _____ Date _____

Relation to Patient _____