

PLEASE PRINT

**Consent For Treatment**

I, AS A PATIENT/LEGAL GUARDIAN, DO CONSENT FOR MEDICAL TREATMENT BY NORTH TEXAS INFECTIOUS DISEASES CONSULTANTS' PHYSICIANS, THIS IS INCLUSIVE OF ANY TREATMENT OR PROCEDURE THEY DEEM MEDICALLY NECESSARY.

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**Signature of Patient/Guardian**

**DATE OF BIRTH OF PATIENT**

**Date**

**Authorization to release medical Information**

THIS IS TO SERVE AS AUTHORIZATION TO RELEASE MEDICAL INFORMATION COMPILED IN THE COURSE OF MEDICAL TREATMENT AT NORTH TEXAS INFECTIOUS DISEASES CONSULTANTS TO THE UNDERSIGNED PATIENT. A COPY OF THIS WILL SERVE AS AN ORIGINAL.

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**Patient's PRINTED Name**

**Signature of Patient/Guardian**

**DATE**

**Assignment of Benefits**

I HEREBY AUTHORIZE ALL PAYMENT FOR MEDICAL SERVICES RENDERED TO MYSELF OR DEPENDENTS TO BE PAID DIRECTLY TO NORTH TEXAS INFECTIOUS DISEASES CONSULTANTS, P.A. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I ALSO AUTHORIZE NORTH TEXAS INFECTIOUS DISEASES CONSULTANTS, P.A., TO FURNISH INFORMATION TO MY INSURANCE CARRIER(S) CONCERNING ANY ILLNESS OR TREATMENT.

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**Signature of Patient/Guardian**

**Date**

<b>Additional Insurance Information</b>