OWENS-FRANKLIN HEALTH CENTER
PRAIRIE VIEW A&M UNIVERSITY
P O BOX 2598
PRAIRIE VIEW, TEXAS 77446-2598
A COMPONENT OF THE TEXAS A&M UNIVERSITY SYSTEM

CONSENT FOR ROUTINE MEDICAL TREATMENT

I _____ have been informed by the staff of the Owens-Franklin Health Center that services will be rendered by or under the supervision of the Medical Director of the Health Center.

I voluntarily consent to such medical treatment as deemed necessary for maintenance of my health and/or life.

I further agree to receive service without reservations, and understand that any condition requiring additional treatment not provided at the Health Center will be appropriately referred.

I have received a copy of the Health Center's Notice of Privacy Practices. Heath Center staff also informed me of how to request my health information and if necessary, how I may lodge a complaint.

Additionally, I understand that I am financially responsible for all services rendered.

Signature:_____ Date:_____

Witness:_____ Date:_____