CONSENT FOR TREATMENT

I voluntarily give my permission to the health care providers of Rheumatology of the Woodlands and such assistants, as they may deem necessary, to provide medical services to me. I understand that by signing this form that I am authorizing them to treat me as long as I seek care from Rheumatology of the Woodlands' providers or until I withdraw my consent.

(Patient/Guardian) Signature _____ Date _____

Printed Name of Patient or Guardian _____ Relationship to Patient _____

Witness Signature _____ Date _____

*A duplicate or faxed copy of this form is considered the same as original document.