Advanced
Gastroenterology of Texas

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Consent for Medical Treatment

I, _____, authorize Advanced Gastroenterology of Texas, PLLC including physicians, physician assistants, nurse practitioners and other employees and staff members to render medical evaluations and care to the patient below. I understand I may revoke this consent at any time by notifying the practice in writing.

I understand that the consent is valid for one (1) year from the date signed unless otherwise specified in writing.

_____ _____
Print Name Date

_____ _____
Signature of Patient of Legal Guardian Relationship to Patient

E-Prescribing Consent

I understand Advanced Gastroenterology of Texas, PLLC uses electronic transactions to prescribe medications. I authorize the practice to request and/or use my prescription history from other healthcare providers/pharmacies for treatment if needed.

Pharmacy_____(Phone)_____

(Address)_____

_____ _____
Print Name Date

_____ _____
Signature of Patient of Legal Guardian Relationship to Patient