Arturo G. Gonzalez, MD, FACS

General Surgery

EXAMINATION OF MINOR CONSENT

I authorize and give consent to a physical examination on _____________________________________, a minor. I authorize Dr. Arturo G. Gonzalez and such assistants as may be designated by him. I also authorize any treatment deemed advisable and necessary. This consent is valid for today and all visits.

Name: _________________________ Relationship: _________________________

Signature: _______________________ Witness: ____________________________

Date: ___________________________ Account # ___________________________