



## Consent to Treat

**Medical & surgical consent:** I, the undersigned, consent to and authorize any examination or medical treatment, and/or services rendered to the patient by the physician/provider or his/her associates which in the judgment of such practitioners are advisable during the course of diagnosis and treatment. It is understood that the practice of medicine is not an exact science, and no guarantee can be given by anyone as to the results that will be attained from any diagnosis or treatment.

**Physicians & independent contractors:** Each patient within Cook Children's Physician Network (CCPN) is under the care of a physician. All physicians are not necessarily employees of CCPN, and therefore, may be independent contractors. Physicians assume responsibility for the medical care they provide.

**Accidental exposure of the healthcare worker:** I understand that Texas law provides that if any healthcare worker is exposed to a patient's blood or other body fluid, CCPN may perform tests on the patient's blood or other body fluid to determine the presence of Human Immunodeficiency Virus (which is the causative agent of AIDS). I give my consent for the testing of other communicable disease, including but not limited to Hepatitis and Syphilis, in the event of an accidental exposure to a healthcare worker. I understand that such testing is necessary to protect those who will be caring for the patient.

**The undersigned certifies that he/she has read and accepts this authorization form and is the patient or the parent of the patient or legally authorized representative of the patient:**

\_\_\_\_\_  
Patient name (please print)

\_\_\_\_\_  
Date of birth

\_\_\_\_\_  
Signature of patient or patient's legally authorized representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed name of authorized representative

\_\_\_\_\_  
Relationship to patient

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date