Associates of Mid-Cities

Consent to Treat

I hereby authorize employees and agents of Endocrine Associates of Mid-Cities (including physicians, physician assistants, nurse practitioners, and other employees and staff members) to render medical evaluations and care to the patient indicated below. I understand that in connection with the patient's treatment, photos or videos may be taken. The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in the case of an emergency.

Today's Date: _____

Print Patient's Name: _____

Patient Date of Birth: _____

Legal Guardian (if different than patient): _____

Patient or Legal Guardian Signature: _____