# Consent to Treat

I hereby authorize employees and agents of Diabetes and Endocrinology Clinical Consultants of Texas (including physicians, physician assistants, and 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 emergency.

**Today's Date:** ______________________________

**Print Patient's Name:** ______________________________

**Patient Date of Birth:** ______________________________

**Legal Guardian (if different than patient):**

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**Patient or Legal Guardian Signature:**

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