PRIVIA MEDICAL GROUP NORTH TEXAS

CONSENT FOR TREATMENT

By signing this consent, I am authorizing my physician(s) and/or order another person to perform all exams, tests, procedures, injections, phlebotomy, and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition. If necessary in the course of my care, I consent for my healthcare provider to access my medication history, if available, from retail pharmacies.

This consent is valid for each visit I make to Dr. _____ with Privia Medical Group North Texas unless revoked by me in writing.

Birth Date _____

_____ _____

Patient/Legal Representative Date