Roland J Dominguez MD PA
2829 Babcock, Suite 407
San Antonio, TX 78229
P (210) 614-5437 | F (210) 949-5051

Authorization for Medical Treatment

I hereby give my consent and authorization to Roland J Dominguez MD PA to provide medical treatment to my child ___________________________ (name of child). I understand that the physician/nurse practitioner will explain any conditions, foreseeable risks and methods of treatment before treatment is provided. I also authorize Roland J Dominguez MD PA to perform any additional treatment thought necessary should any emergency situation arise.

In my absence, I authorize these individuals to seek care for my child/children.

Name: ______________________ Relationship: _____________ Phone: ___________________

Name: ______________________ Relationship: _____________ Phone: ___________________

____ __________________________________
Patient/Guardian Signature Date

____
Relationship to Patient

Notice of Privacy Practices

Patient Name: ____

Date of Birth: ____

I acknowledge that Roland J Dominguez MD PA provided me with a written copy of his Notice of Privacy Practices.

I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

____ __________________________________
Patient/Guardian Signature Date

____
Relationship to Patient