

Authorization to Treat a Minor

Patient Name

File#

Date

Authorization

I hereby request and authorize the performance of diagnostic tests, procedures and treatment for my minor child.

As of this date, I have legal right to select and authorize health care services for the minor child named above.

(if applicable) Under the terms and conditions of my divorce, seperation or other authorization, the consent of a spouse/former spouse or other parent is not required. If my authority to so select and authorize this care should be revoked or modified in anyway, I will immediately notify Advanced Chiropractic and Wellness, PC.

Printed Name _____ Relationship to Minor Patient _____

Signature _____ Date _____

Witness _____ Date _____