Consent to Treat a Minor Child

Patient Name:_____

I, as the parent or legal guardian, hereby request and authorize Dr. Daven L. Spencer to perform diagnostic tests and render chiropractic adjustments and other supportive therapies to:_____.

This authorization is extended to other staff members and is intended to include radiographic examination at the doctor's discretion.

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

(If Applicable) Under the terms and condition of my divorce, separation or other legal 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 any way, I will immediately notify this office.

_____ _____
Signature Date

_____ _____
Printed Name Relationship to Patient

_____
Office Staff