Consent to Treatment (Minor)

PATIENT NAME: _____

I hereby request and authorized Dr. Jacklyn Casab to perform diagnostic tests and render chiropractic adjustments and other treatment to MY MINOR SON/DAUGHTER: _____. This authorization also extends to all other doctors and office 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 minor child named above.

(If applicable) under the terms and conditions of my divorce, separation, or other legal authorization, the consent of a spouse/former spouse or other parent is not required. If my authority is so select and authorize this care should be revoked or modified in anyway, I will immediately notify this office.

Date: _____

Witness: _____

Guardian Signature: _____

Printed Name: _____

Relationship to Patient: _____