Consent to Treatment (Minor)

Patient Name: _____

I hereby request and authorize Dr. Hudson to perform diagnostic tests and render chiropractic adjustments and other treatments to_____. This authorization also extends to all others 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 rights 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 to so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

_____
Parent Signature

_____
Print Parent Name

_____
Relationship to Patient

_____
Date

FOR OFFICE USE ONLY

_____ _____

Authorized Provider Representative **Date**