Authorization to Treat a Minor

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 below.

(If Applicable) Under the terms and conditions of my divorce, separation or other authorization, the consent of my 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 Back In Body.

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Minor Patient Name (Please Print)

____________________________________ ________________________
Name (Please Print) Relationship to Minor Patient

____________________________________ ________________________
Signature Date

Martha DeSante, DC, CYT
Chiropractor Name

____________________________________ ________________________
Chiropractor Signature Date