# Maiden Community Chiropractic

## Consent to Treat a Minor

Patient's Name: ______________________________________

I hereby request and authorize Maiden Community Chiropractic to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor (son/daughter) listed above. This authorization also extends to all staff members and is intended to include radiographic examination at the doctor's discretion. As of the date, I have the legal right to select and authorize health care services for the minor 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 anyway, I will immediately notify this office.

Signature: ______________________________________

Printed Name: ______________________________________

Relationship to Patient: ______________________________

Witness: ______________________________________

Date: ______________________________________