Consent to Treat a Minor*

Life Line
chiropractic & massage

Date _____

Patient_____

I request and authorize Dr. Tammy Costello to perform diagnostic tests, render chiropractic care, as well as other treatment to _____.

This authorization also extends to all other doctors and staff members, and is intended to include radiographic examination at the doctor's discretion. It is not necessary to have one of the people listed below accompany the minor for treatment. I understand that Dr. Costello has the right to refuse treatment, even when the minor is unaccompanied. I also give permission for _____to be treated without my presence and/or the other persons listed below.

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

I authorize the following caregivers to accompany the minor for treatment.

Name	Relationship to Minor

(If applicable) Under the terms and conditions of my divorce, separation, or other legal authorization, the consent of the 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.

_____ _____

Print Name Signature

_____ _____

Relationship to Patient Witness

* A "Minor" is defined as Age 17 or under

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