Chiropractic, Serving the San Antonio Area for over 20 years!

7623 Tezel Road San Antonio, Texas 78250 (210) 680-5133

CONSENT TO TREATMENT OF A MINOR

I hereby request and authorize Dr. Pamala Mitchell, and whomever she may designate as her assistant or authorized representative, to administer chiropractic care as she deems necessary to my dependent minor child. This authorization also extends to include diagnostic imaging, laboratory and other testing at the doctor's discretion.

CHILD'S NAME:____

YOUR RELATIONSHIP TO CHILD: ☐ Mother ☐ Father ☐ Legal Guardian

As of today's date, I have the legal right to select and authorize health care service 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.

TODAY'S DATE:_________________

NAME (PRINT): _______________________

SIGNATURE:__________________________
PARENT/GUARDIAN