WASHINGTON PARK
CHIROPRACTIC
heal thrive evolve

CONSENT TO TREATMENT (MINOR)

PATIENT NAME: _____

I hereby request and authorize Dr. Lisa Goodman, Dr. Chad London and Dr. Chris Dorsa to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor son/daughter _____. This authorization also extends to all other doctors and office staff members.

As of this date, I have the legal right 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.

Date: _____ Signature: _____

Witness: _____ Printed Name: _____

Relationship to Patient: _____

1313 S. Clarkson St. Unit 1, Denver, Colorado 80210 phone: 303-744-7100 fax: 303-744-7109 washparkchiro.com