Authorization to Treat Minor Patient in Absence of Parent/Guardian

Name of minor patient: ________________________________ Date of Birth: ____________________

I certify that I am the parent and/or legal guardian of ____
(*Name of child*)

☐ I authorize ___________________________ to bring my child to the clinic named below and to the
(name of person bringing child to office)

rendering of chiropractic care, including diagnostic procedures, x-rays and treatment by Dr. Richardson and/or other licensed Doctors of Chiropractic working at this clinic.

☐ I authorize the minor child named above to come alone to the clinic named below and to the rendering of chiropractic care including diagnostic procedures, x-rays and treatment by Dr. Richardson and/or other licensed Doctors of Chiropractic working at this clinic.

This authorization:

☐ is effective on ____________________________.

☐ is effective from __________________________ to ____________________________.

☐ is effective until revoked by me in writing.

Parent/Legal Guardian Contact Information:

Home phone number ____________________ Office phone number ____________________

Cell phone number _____________________ Other phone number ____________________

I reserve the right to revoke this authorization at any time by writing to the below-named physician.

Parent/Guardian Signature: _______________________________________

Chiropractic Caring For You, LLC
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