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# CONSENT TO TREATMENT OF MINOR

(I) (We), the undersigned, parent(s)/person having legal custody/legal guardianship of

\_\_\_\_\_, a minor, do hereby authorize Dr. Myles Starkman  
(name of minor) (agent)

and staff of Oasis Chiropractic Center to administer such procedures & treatment to the  
agent(s)

above mentioned (minor) as necessary. I hereby certify that I have the authority and the responsibility to authorize treatment for this child.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

I have read this form and certify that I understand its contents.

I intend this consent form to cover the entire course of treatment for the child's (minor) present condition(s) and for any future condition(s) for which (I) (We), the undersigned, parent(s)/person having legal custody/legal guardianship seek treatment for at this facility.

\_\_\_\_\_  
Please print name(s) Parent(s), Guardian or Personal Representative Relationship to Patient

\_\_\_\_\_  
Signature(s) of Parent(s), Guardian or Personal Representative

\_\_\_\_\_  
Date