N2HEALTH - CHIROPRACTIC & ACUPUNCTURE

CONSENT TO TREATMENT OF MINOR

Patient Name: _________________________

I hereby request and authorize **Dr. Coleman** and/or **Dr. Hashimoto** to perform diagnostic tests and render acupuncture, chiropractic and/or nutritional therapy treatment to ______________________________. This authorization also extends to all other doctors or licensed practitioners and office staff members.

As of the 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

____

Printed Name

____

Relationship to Patient