

CONSENT TO TREATMENT OF MINOR

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

_____, a minor, do hereby authorize _____
(name of minor) (name of agent)

Dr. Michael Hafkey, D.C. as agent(s) for the undersigned to consent to any x-ray examination and chiropractic diagnosis or treatment, which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

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.

These authorizations shall remain effective until _____, _____, unless sooner
(month and day)
revoked in writing delivered to the agent(s) noted above.

Date: _____

Signature: X
(parent/legal guardian/person having legal custody) (circle relationship)

Signature: X
(parent)