Consent to Treatment (Minor)

PATIENT NAME: _____

I hereby request and authorize _____, LMT to perform a general health screen and render massage therapy and other related treatments to _____. This authorization also extends to all other office staff members.

As of this date, I have legal right to select and authorize health care services for the minor child named above.

(If Applicable) Under 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.

NAME OF GUARDIAN (PRINT): _____
SIGNATURE OF GUARDIAN: _____ **DATE:** _____
RELATIONSHIP TO PATIENT: _____

WITNESS (PRINT): _____
WITNESS SIGNATURE: _____ **DATE:** _____