

ON THE GO CHIRO - Dr. Tory Brooks, Chiropractic Physician
3250 N. Campbell Ave., Suite 132, Tucson, AZ 85719 520.881.0650

CONSENT TO TREAT A MINOR

PATIENT NAME: _____

I hereby request and authorize Dr. Tory Brooks to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor child: _____ .
This authorization also extends to all other doctors and staff members and is intended to include radiographic examination at the doctor's discretion.

As of this date, I have the legal right to select and authorize healthcare 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: _____

Witness Printed Name

Parent or Guardian Printed Name

Witness Signature

Parent or Guardian Signature

Relationship