ELITE MEDICAL CLINIC

2214 South Hoover Street
Los Angeles, CA 90007

Phone: 213.622.3100 Fax: 213.622.3132

CONSENT FOR TREATMENT OF A MINOR

We/I, the undersigned _____, parent(s) and/or guardian(s) of a minor child _____, give you full and unconditional authority to proceed with a clinical evaluation and treatment as your judgment indicates. This consent is given by me/us as parent(s) and/or guardian(s) of said child. We/I have legal power to consent to medical, psychological, and mental health assessment and treatment of said minor child. It is clearly understood that you are hereby fully released from any claims and demands that might arise, or be incident to the evaluation and/or treatment, provided that your duties are performed with standard care and responsibility to the best of your professional ability. I realize that at times the nature and/or content of such services must remain private. Therefore, I hereby release any right I may have to the information contained in the file of my son, daughter, or ward which may be generated as a result of such services.

Signed this _____day of _____, 20_____

_____
Mother or Guardian

_____
Father or Guardian

The above explained to: (circle all that apply) Mother / Father / Guardian

By _____on the _____day of _____, 20_____

_____
Witness

_____
Date