CONSENT TO TREAT A MINOR

I, _____, am the legal guardian or parent of
Print guardian/parent name

_____. I understand that by signing this
Print patient name

Authorization, I authorize any physician of Canadian Valley Family Care to

provide Treatment to _____ in the event that
Print patient name

I, _____ am not available to attend the appointment.
Print guardian/parent name

_____ _____
Signature of Legal Parent/Guardian Date

_____ _____
Signature of Witness/Title Date

THIS AUTHORIZATION WILL BE HONORED UNLESS IT IS REVOKED BY NOTIFYING OUR OFFICE IN WRITING