



Consent for Treatment of Minor without Parent Present

This form serves as consent for our office, Grapevine Chiropractic, Dr. Christy Porterfield and any persons employed by the office to provide treatment of _____, a minor, without direct parental oversight.

I, _____ (parent), am aware of all procedures performed, including musculo skeletal therapies, low light laser therapy, and adjustive procedures. All of my questions have been answered.

Your signature indicates your authorization of this activity.

Name (printed)

Signature of parent

Date

This authorization may be revoked by you at any time. Revocation may be accomplished by advising us in writing of your desire to withdraw your authorization. Please allow a reasonable processing time for the change in our procedures to be completed.