



191 Route 59 – Suffern, NY 10901  
(845)369-7611

### **Treatment of Minor Consent**

I hereby authorize Dr. Joseph O'Brien and whomever he may designate as assistants to perform diagnostic tests and render chiropractic adjustments and other treatment to **MY MINOR CHILD:** \_\_\_\_\_.

As of this date, I have the legal right to select and authorize health care 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: \_\_\_\_\_

Signature: \_\_\_\_\_

Witness: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_