<u>Pitts Family Chiropractic</u>

Consent to treatment of a minor
(under the age of 18)

801 NE 25TH AVE
Ocala, Fl 34470
Phone 352-732-0200
Fax 352-732-2623

I hereby request and authorize the above named doctor/clinic to perform diagnostic tests and render a diagnostic examination if the doctor deems necessary, chiropractic adjustments and treatments for:

____

(Patient Name)

As of this date, I have the legal right to select and authorize health care services for this minor. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

____

(Parent/Guardian Print Name)

____

(Parent/Guardian Signature)

____

(Relation to Patient)

____ / ____ / ____

Date