

CONSENT TO TREATMENT OF MINOR

Karen S. Thomason, D.C.

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Telephone (281) 580-1961

I hereby request and authorize the above named doctor/clinic to perform diagnostic test and render chiropractic adjustments and other treatment to my _____ (indicate relationship to child)

(Name of Child)

This authorization also extends to all other doctors and office staff members and is intended to include radiographic examination at the doctor's discretion.

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

Signature

Date

Printed Name

Relationship to Patient