Larkfield Family Chiropractic
Dr. Michelle Kobbe
534 Larkfield Rd, E.Northport NY11731
631-262-0015

CONSENT TO TREATMENT OF A MINOR

Patient Name: _____

I hereby request and authorize **Michelle Kobbe, D.C**. to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor [son][daughter] named_____. This authorization also extends to all other doctors and office staff members and is intended to include referral for radiographic examination at the doctor's discretion.

As of the 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 select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Date:_____ _____
Signature

_____
Printed Name

_____
Relationship to Patient