Alliance Integrative Medicine

AUTHORIZATION FOR TREATMENT OF MINORS

I, _________________________________ , being the parent, custodial parent, or legal guardian of the

(Please print your name above)

minor patient, ____ ; date of birth: ________________ ,

(Please print patient's name above) (Please put patient's DOB above)

hereby give my authorization to the Alliance Integrative Medicine providers for medical

treatment and/or diagnostic testing (laboratory, etc.) on this the ____ day of_________________ , 20__

This authorization is valid until revoked in writing.

Signed: ___________________________________

Your relationship to patient: _______________________________

Address: __________________________________

____

Home Phone #: ( )___________________ Cell Phone #: ( )___________________