**Desert Shadows Chiropractic and Wellness**

**Dr. Christopher C. Campo, D.C.**

**4010 E. Bell Road Ste: 103**

**Phoenix, Az 85032**

**602-595-0015**

# CONSENT TO TREATMENT OF MINOR

(I)(We), the undersigned parent(s)/person having legal custody/legal guardianship of :

_____, a minor, do hereby (minor name) authorize:

_____,(name of agent) as agent (s) for the Undersigned

to consent to any x-ray, examination and chiropractic diagnosis or treatment which is deemed advisable by a licensed chiropractor, be rendered under the general or special supervision of any licensed chiropractor.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnosis and treatment which chiropractor, meeting the requirements of this authorization, may, in the exercise of his/her best judgment, deem advisable.

This authorization shall remain effective until _____Unless sooner revoked in writing delivered to the agents noted above.

Signature:_____ Date:_____

(Parent/Legal guardian, circle one)