Minor Consent for Another Adult

I, ____
parent(s) or guardian(s) name(s)

give permission to ____
name(s)

to make medical decisions for the following child, _____________________________________
patients name

_____ / _____ / __________. I understand that I as the parent/guardian am fully responsibly
patients date of birth

for patients account balance and all balances or charges for the date of service is to be paid at

the appointment time.

Signature: ____
Parent or Guardian

Date: ___________________________