CONSENT TO TREATMENT OF MINOR

ChiroCentric, L.L.C.
Kimberly DeAlto, D.C.
12620 SW 3rd Street
Beaverton, OR 97005
(503) 430-7371

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

_____ (Name of Child)

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