Total Care Chiropractic
22706 Aspan Street, Ste. 603-B
Lake Forest, CA 92630
949-380-1166

Treatment of Minor Consent

Date:________________________________

I _______________________hereby authorize Dr. Michael S. Linnell and whomever he may designate as assistants to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor child: ____.

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

Parent or Legal Guardian:____

Signature: ____