INTEGRITY HEALTH CENTERS PLLC
910 HWY 62-65 N, HARRISON, AR 72601

870-704-4072
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CONSENT TO TREAT A MINOR

PATIENT'S NAME	ACCT

I (we) being the parent, guardian or custodian of the minor

NAME OF PATIENT: _____

SOCIAL SECURITY: _____

DATE OF BIRTH: _____ AGE: _____

do hereby authorize, request and direct the doctors office as shown above and staff to perform examinations, diagnostic tests, x-rays, laboratory test and any treatment that in their judgment, is deemed advisable or required.

It is the understanding of the undersigned that the physicians and their staff shall have full authority from me as legal parent/guardian to continue with examinations, diagnostic tests and treatments as will be needed while said minor shown above is under care in the office until legal age is attained.

A minor child as described by law. Further I warrant that my authority to act on the child's behalf is by virtue of:

[ ] Being the child's natural parent

[ ] Having been duly appointed legal guardian by a Court of Competent Jurisdiction. (A copy of the order is attached hereto)

I agree to be held fully responsible for all costs for all treatment and/or care rendered to this child.

_____ _____

Signature of Parent or Legal Guardian Date Signed

_____

Witnessed by Staff / Signature

NOTE: Custodial Guardians must provide proof of legal guardianship

- original copy is retained for records -
- photocopy may be released -