AUTHORIZATION TO TREAT A MINOR

I, _____, am the parent / legal guardian (circle one) of:

Minor's Name: _____
Date of Birth: _____

I hereby authorize **Neuroscience and Spine Associates**, its physicians, nurses, and other medical personnel, to provide medical examination, diagnostic procedures, and treatment for the above-named minor in my absence.

This authorization applies to:

☐ Routine medical care
☐ Emergency medical treatment
☐ Other (specify): _____

In the event of an emergency, I authorize the following individuals to consent to treatment on my behalf (optional):

1. Name: _____ Relationship: _____ Phone: _____

2. Name: _____ Relationship: _____ Phone: _____

Medical Information (optional):

Allergies: _____

Medications: _____

Relevant medical conditions: _____

Insurance Information:

Carrier: _____ Policy #: _____
Group #: _____ Phone: _____

This consent will remain in effect from _____ to _____, unless revoked in writing.

Parent/Guardian Name (print): _____

Signature: _____ Date: _____

Address: _____

Phone: _____ Email: _____

Witness Name (print): _____

Witness Signature: _____ Date: _____