WILCOX family CHIROPRACTIC

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Authorization For Minor To Be Unaccompanied By Guardian

Patient/Minor Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

Phone Number: _____

I, as parent/guardian, give consent for the above patient to be evaluated and treated when unaccompanied by myself or another guardian at Wilcox Family Chiropractic. This authorization is valid until I give notice otherwise.

_____ _____

Parent/Guardian Signature Date