STOIBER CHIROPRACTIC

Patrick G Stoiber, DC Lauren M Stoiber, DC
Victoria A Zueger, DC

1720 Grove Ave
Wisconsin Rapids, WI 54494
(715)-424-8000

Authorization to Treat Minor Patient in Absence of Parent/Guardian

Name of minor patient: _____ Date of Birth: ___/___/_____

I certify that I am the parent and/or legal guardian of _____
(Name of child)

☐ I authorize _____ to bring my child to office visits with
(Name of person bringing child to office)
Dr. _____ .
(Name of doctor)

☐ I authorize the minor child named above to come alone to office visits with Dr. _____ and I consent to the examination and/or treatment and X-Rays of my child.
(Name of doctor)

This authorization:

☐ is effective on ___/___/_____

☐ is effective from ___/___/_____ to ___/___/_____

☐ is effective until revoked by me in writing.

I reserve the right to revoke this authorization at any time by writing to the above-named doctor.

Parent/Guardian Name Printed:_____

Parent/Guardian Signature:_____ Date: ___/___/_____

Witness Signature: _____ Date: ___/___/_____