

Medical Massage Center, Inc.
8370 W. Coal Mine Ave., Suite 106
Littleton, CO 80122
303-979-0342



CONSENT TO TREAT A MINOR

Minor's Name _____
Please Print

I hereby request and authorize the therapists of Medical Massage Center, Inc., to render medical massage therapy to _____ (minor). This authorization extends to all massage therapists employed by Medical Massage Center, Inc.

As of this date I have the legal right to select and authorize healthcare service for the minor child named above.

Under the terms and conditions, if applicable, of a court ordered custody arrangement or other legal authorization, the consent of a spouse, former spouse, or other parent is not required. If my authority to select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

Date

Signature

Printed name

Witness

Relationship to Patient