Patients name: _______________

Dr. Abbey H. Ike , DC

TREATMENT OF MINOR CONSENT

I hereby request and authorize Dr. Anna Hernandez, DC to perform diagnostic tests and render chiropractic adjustments and other treatment to my minor: ________________. This authorization also includes radiographic examination at the doctor's discretion.

As of the date, I have the legal right to select and authorize health care services for the minor child named above.

(If applicable) Under the terms and conditions of my divorce, separation or other legal authorization, the consent of a spouse/ former spouse or other parent is not required. If my authority to do select and authorize this care should be revoked or modified in any way, I will immediately notify Prana Health Chiropractic.

___________________	_________________________
Date	Signature
________________________	________________________
Witness	Printed Name
	________________________
	Relationship to Patient

18377 Beach Blvd. Suite 217, Huntington Beach, CA 92648

714-465-2127 info@pranahealthchiropractic.com