Dr. Darren Mollo
1786 Flatbush Ave
Brooklyn, NY 11210

CONSENT TO TREAT A MINOR

PATIENT NAME: _____ **DATE OF BIRTH**: _____

By signing this paper, the parent and/or guardian is authorizing all doctors and practitioners affiliated with the above facility to administer treatment to their minor child. Treatment may be ongoing, even in my absence.

I, _____, hereby authorize In Motion Chiropractic, P.C. and **Dr. Darren T. Mollo** , and whomever he/she may designate as their assistance to administer treatment as he/she so deems necessary to my son/daughter, _____

Legal Guardian/Closest Relative

This document has been signed and witnessed on _____/_____/_____ and remains in effect until withdrawn in writing.

Today's Date

_____
Signature of Legal Guardian/Closest Relative

_____
Relationship to Child

_____
Signature of Witness