Stay in Touch, LLC
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CONSENT TO TREATMENT OF A MINOR

(I)(We), the undersigned, parent(s) or person having legal custody or legal guardianship of

_____, a minor, do hereby authorize
(Minor's Name)

_____, as agent(s) for the undersigned
(Agent's Name)

to consent to any x-ray, physical examination and diagnosis or treatment, which is deemed advisable by a contracted acupuncture provider to be rendered under the general or special supervision of any contracted acupuncture provider.

It is understood that this authorization is given in advance of any specific diagnosis or treatment being required but is given to provide authority to the above described agent(s) to give specific consent to any and all such diagnoses and treatments which the acupuncture provider, meeting the requirements of this authorization, may, in the exercise of his or her best judgment, deems advisable.

This authorization shall remain effective until_____,_____,
(Month and Day) (Year)

unless sooner revoked in writing delivered to the agent(s) noted above.

Date_____

Signature_____
(Parent/legal guardian/person having legal custody) (Circle relationship)

Signature_____
(Parent)