Atlantic Medical Imaging

Consent to Treat a Minor

As the patient or guardian of _____, I am granting the
(Print Child's Full Name)

person(s) listed below permission to bring my child in the treatment and/or care on _____.
(Date of Visit)

The below person(s) will be permitted to approve any additional treatment needed during this visit, fill out all necessary paperwork (including the Financial Policy) and will have access to all medical information required for the treatment of my child during this visit.

Please list person(s) here	**Relationship**
_____	_____
_____	_____
_____	_____

_____ _____

Parent/Guardian Signature **Date**