AFFILIATED NEUROLOGY CENTER

25982 Pala, Suite 150
Mission Viejo, CA 92691

Telephone: 949-586-5500
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CONSENT TO TREAT MINOR CHILD

I, ____________________________________ hereby authorize Affiliated Neurology Center
(print name of parent /guardian)

and whomever they designate as assistants to administer treatment as deemed necessary to my

_______________________________________ __________________________________.
(son/daughter/other- indicate relationship) (name of minor)

Parent/Guardian Signature: ___________________________Date:______________________

Relationship to minor: ____

Witness: ____Date:______________________