

## Integrative Healthcare Partners

**PATIENT NAME:** \_\_\_\_\_

I hereby request and authorize Dr. \_\_\_\_\_ to perform any appropriate care to \_\_\_\_\_. This authorization also extends to all other doctors and office staff members and is intended to include examination at the doctor's discretion.

As of this 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 so select and authorize this care should be revoked or modified in any way, I will immediately notify this office.

**DATE:** \_\_\_\_\_

**SIGNATURE** \_\_\_\_\_

**PRINTED NAME** \_\_\_\_\_

**RELATIONSHIP TO PATIENT** \_\_\_\_\_

**WITNESS** \_\_\_\_\_