

# Alliance Institute for Integrative Medicine

## AUTHORIZATION FOR TREATMENT OF MINORS

I, \_\_\_\_\_, being the parent, custodial parent, or legal guardian of the  
(Please print your name above)

minor patient, \_\_\_\_\_; date of birth: \_\_\_\_\_,  
(Please print patient's name above) (Please put patient's DOB above)

hereby give my authorization to the Alliance Institute for Integrative Medicine providers for medical treatment and/or diagnostic testing (laboratory, etc.) on this the \_\_\_\_ day of \_\_\_\_\_, 20\_\_

This authorization is valid until revoked in writing.

Signed: \_\_\_\_\_

Your relationship to patient: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Home Phone #: (     ) \_\_\_\_\_

Cell Phone #: (     ) \_\_\_\_\_