

CONSENT TO TREAT A MINOR

THIS FORM MUST BE COMPLETED BY A PARENT OR LEGAL GUARDIAN
THIS FORM IS GOOD FOR ONE YEAR FROM TODAY'S DATE

We realize that Parents or Legal Guardians may not always be able to personally bring their child to the office themselves. If a Parent or Legal Guardian cannot be present, then anyone authorized on this form can accompany the child and give consent for treatment.

I, _____, the Parent or Legal Guardian of _____, give consent for the following people to be treated by Brian Coder, D.O., Karen Yarusso, PA-C, Christina Clark, PA-C, Allison Griffiths, PA-C, Jayme Montgomery, NP-C, and staff.

Authorized People	Relationship
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

I have received a Notice of Privacy Practices from Broken Arrow Family Clinic

Signature _____ Date _____