AFFILIATED NEUROLOGY CENTER

25982 Pala, Suite 150
Mission Viejo, CA 92691

Telephone: 949-586-5500
Fax: 949-586-1600

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:_____