INTEGRATIVE WOMEN'S HEALTHCARE OF NEVADA
ROBI BURNS, M.D.

CONSENT FOR MEDICAL TREATMENT OF A MINOR

I am the parent(s) of the minor child _____ (CHILD NAME). I temporarily entrust _____ (CHILD NAME) to the care of Robi Burns, M.D./Integrative Women's Healthcare of Nevada whose address is at 2633 W. Horizon Ridge Pkwy Ste 100 Henderson, NV 89052.

I authorize Robi Burns, M.D./Integrative Women's Healthcare of Nevada to consent to medical care for _____ (CHILD NAME). "Medical care" includes X-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care under the general or special supervision and upon the advice of or to be rendered by a physician and surgeon licensed under the Medical Practice Act.

( ) I give permission for my child to be seen at the practice even if I am not present.

( ) I do not give permission for my child to be seen at the practice if I am not present.

Signature_____Dated: _____

Please Note: By law the signature of only one parent gives the authorization stated above.