

Dr. Steven M. Pittson D.C.  
Doctor of Chiropractic

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## CONSENT TO TREATMENT OF MINOR

I (We) being the parent or guardian of \_\_\_\_\_, a minor,  
whose date of birth is \_\_\_\_/\_\_\_\_/\_\_\_\_ & age (\_\_\_\_) do hereby consent, authorize and  
request **Dr. Steven M. Pittson D.C.** to administer such treatment deemed advisable,  
necessary or requested on the above minor. I also authorize **Dr. Steven M. Pittson D.C.**  
to take x-rays, urinalysis or ROM/MT as/if needed.

I (We) agree to hold him free and harmless from any claims, suits for damages or  
complications which may result from such treatment or testing.

Print (Parent/Guardian) \_\_\_\_\_

Signed: \_\_\_\_\_  
Parent of Guardian of minor

Date: \_\_\_\_\_

Witness: \_\_\_\_\_

Date: \_\_\_\_\_