NAME OF PATIENT ____

DATE ____

CONSENT TO TREATMENT OF MINOR CHILD

CONSENT TO TREATMENT OF ADULT WITH MEDICAL POWER OF ATTORNEY

I hereby authorize Dr. Wasinger and whomever he/she may designate as his/her assistants to administer treatment, as he/she so deems necessary to ______________________________ (Name of Patient).

Dated at _____________ day of ______________, 20_______.

____

Printed name of person authorizing treatment

____

Signature

Relationship to patient: ___________________________________

IF YOU ARE CONSENTING ON BEHALF OF AN ADULT, DO YOU HAVE MEDICAL POWER OF ATTORNEY? ( ) Yes ( ) No
(Please provide our office with a copy of the medical Power of Attorney).

Witnessed: ____