

AFFILIATED NEUROLOGY CENTER

25982 Pala, Suite 150
Mission Viejo, CA 92691

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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: _____