Goode Integrative Health Care

Consent to Treatment of Minor Child

I hereby authorize <u>Dr. Robert J. Goode III</u> and/or <u>Dr. John A. Pixler</u> and/ or his staff to examine and/ or treat my daughter/son.

Full Name of Child:			
Address:			
Signed:	_		
Dated:			
Witness:			
Dated:			