SYNERGY Therapeutic Group

12 S. Division St
DuQuoin,IL 62832
618-542-8950

1110 Cedar Court
Carbondale, IL 62903
618-529-4360

CONSENT TO TREAT A MINOR

Parent Name: _____

Address: _____

CITY: _____ ST _____ ZIP _____

PHONE: _____ SS# _____

I HEREBY AUTHORIZE:

The above named doctors or any doctors associated with the above named practice, and whomever he/she/they may designate as assistants, to administer the required care as deemed necessary to my _____(indicate relationship of child)

_____
(Name of Child)

Signed: _____ Date: _____

Witnessed: _____