

1260 35th St, Ste 2, Marion, IA 52302

Phone: 319-826-6374 Fax: 319-826-6377

**Minor Consent for Treatment**

I am the parent, guardian, or custodian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. There are no current court orders which prohibit me from signing this consent.

I hereby authorize the doctor and practice staff to perform services deemed necessary, whether or not I am present, when the services are rendered.

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 Signature of parent, guardian, or custodian Date