Paul Spencer, D.O.
Mary Paquette, M.D.
Matthew Paquette, M.D.
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# CONSENT TO TREATMENT OF A MINOR

Minor's name:_______________________________________Date of Birth:________________

Medical Record Number: _____________________

I hereby authorize the providers of AALFA Family Clinic and such assistants as the providers may designate to administer treatment to the above-named minor at such intervals as are necessary for the minor's health and best interest. Treatments may be administered whether or not such minor is alone or accompanied by another adult or me.

I understand that you will make every effort reasonable to notify me of a situation and obtain my preferences. If such efforts to contact me are unsuccessful or if the situation requires action without delay, I authorize the above named personnel of AALFA Family Clinic to take such action as is medically necessary on the minor's behalf.

Phone Number for Parent/Guardian: __________________________________________________

**I understand that this consent will last for one year unless I change my mind and withdraw by consent sooner in writing. If I withdraw consent, it will not affect actions already taken.**

______________________ ________________________________________________

Date Signature of Parent of Guardian

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