



Authorization to Treat a Minor

I, _____ authorize treatment of my child, _____
without my presence to be treated by Dr. Valerie Skow and/or Dr. Tammy Watkins at Heartland Chiropractic and
Wellness Center.

**Any specific written authorization you provide may be revoked at any time by writing to us at the address
provided at the end of this notice.**

PATIENT: _____ Date of Birth: _____
Name (Print) Social Security# _____

Signature: _____ Date: _____