

CONSENT TO TREATMENT OF A MINOR

This form is to be completed for each minor and filed in the minor's chart.

DATE: _____

TO: Alan Hamilton M.D. P.C., Associates, Nurses and Staff Members,
5424 E Bell Rd, #145, Scottsdale, AZ 85254
602-354-3172 Fax 602-354-3173

RE: _____, a minor.

DATE OF BIRTH: _____

I, _____ parent(s) or legal guardian(s) of
_____, a minor, authorize Alan Hamilton M.D. P.C.,
Associates, Nurses and Staff Members, to whom the minor has been entrusted, consent to
treatment and care deemed advisable to include examination, x-ray, anesthetic and
surgical procedure to be rendered to said minor.

This consent shall remain effective until _____, 20____, unless sooner revoked
in writing and delivered to Alan Hamilton M.D., P.C..

DATE: _____

Parent or Legal Guardian (signature)

DATE: _____

Witness (print)

Witness (signature)

Title