



CONSENT TO TREAT A MINOR

Patient Name _____ Date of Birth _____

I, the parent/guardian of _____, a minor, do hereby authorize
_____ and the staff of Kachina Family Practice to
provide ongoing routine and emergency health care. This consent will remain effective until
_____, or until revoked in writing.

(Signature of Parent/Guardian) (Date)

(Signature of Witness) (Date)