THE BODYWORKS WELLNESS CENTER
healing the world one massage at a time

17 Computer Drive East

Albany, New York 12205

518-459-HEAL (4325)

www.thebodyworkswellnesscenter.com

Authorization to Treat Minor

Name of minor client: _____

Date of Birth: _____

☐ I certify that I am the parent and/or legal guardian of

_____.
(Print Name of Child)

☐ I authorize _____ to treat
(Print Name of Therapist)

_____
(Print Name of Child)

☐ I authorize _____ to bring my child to office visits.
(Print Name of Person Bringing Child to Office)

☐ I authorize the minor child named above to come alone to office visits with
___ _____ and I consent to the treatment of my child.
(Print Name of Therapist)

This authorization:

☐ is effective on _____.

☐ is effective from _____ to _____.

☐ is effective until revoked by me in writing.

Parent/Legal Guardian Contact Information:

Home phone number _____ Office phone number _____

Cell phone number _____ Other phone number _____

I reserve the right to revoke this authorization at any time by writing to the above-named therapist.

Parent/Guardian Signature: _____ Date: _____