

# *Michigan Foot & Ankle Specialists*

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## **CONSENT TO TREATMENT OF MINOR**

Name of Minor: \_\_\_\_\_

Birth Date of Minor: \_\_\_\_\_

Name of Parent/Guardian: \_\_\_\_\_

I AM THE PARENT/GUARDIAN OF THE MINOR CHILD WHOSE NAME AND BIRTH DATE ARE INDICATED ABOVE. I HERBY GIVE PERMISSION TO DR. ALEXANDER P. THOMAS AND ANY OTHER DOCTORS PRACTICING IN THIS OFFICE WITH DR. ALEXANDER P. THOMAS TO EXAMINE AND TREAT THE ABOVE-NAMED MINOR CHILD FROM THIS DATE FORWARD. THIS AUTHORIZATION IS VALID UNTIL REVOKED IN WRITING.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Parent/Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness