65 S. Wadsworth Blvd.
Lakewood, CO 80226
Ph. 303-934-3600
Fax: 303-934-1559

CONSENT FOR TREATMENT OF A MINOR

Minor's Name_____

I hereby authorize LifeSource Health Partners and all providers connected with the clinic to administer care as deemed necessary. This will include appropriate evaluation including physical examination, treatment and if necessary X-rays.

_____
Relationship to the Minor

_____ _____
Signature Date