Consent for Treatment

I authorize that the following person(s) may bring my child/the patient for treatment with Dr. Porter and/or Dr. Galloway. I understand that anyone who is NOT listed below, may NOT bring my child for treatment without a parent or legal guardian present.

Full Name: ____ Phone: ________________________

DL# and State: _____________________________ Relationship to Patient: _______________________

Full Name: ____ Phone: _______________________

DL# and State: _____________________________ Relationship to Patient: _______________________

Full Name: ____ Phone: _______________________

DL# and State: _____________________________ Relationship to Patient: _______________________

Full Name: ____ Phone: _______________________

DL# and State: _____________________________ Relationship to Patient: _______________________

You will be required, in the future, to provide our office with written authorization before your child arrives for an appointment with someone other than a parent/legal guardian or any person listed above.

☐ I understand and agree to the above authorization.

Parent/Guardian Signature: ____ Date: ____________