MINOR AUTHORIZATION

STILLWATER SPINE & SPORTS CENTER , INC
80 Four Mile Drive Suite 16
Kalispell, MT 59901

I being the parent, guardian, or custodian of the minor being_____, age_____, do hereby authorize, request, and direct the doctor and staff to perform examinations, diagnostic x-rays, laboratory tests, and any treatment that in their judgment is deemed advisable or is required while said minor is under care of Stillwater Spine & Sports Center, Inc. All charges for services and care given to said minor will be charged directly to myself and I will be personally responsible for payment of them. I hereby authorize the doctor to release all information necessary to secure payments of benefits. I authorize the use of this signature on all insurance submissions and/or requests pertaining to the said minor's physical condition, including, but not limited to, all records, reports, progress notes, reports of diagnostic tests, x-rays and/or medical opinions.

_____

_____
Parent, Guardian, Signature

_____
Relationship

_____/_____/_____
Date