255 Intervale Road, New Gloucester ME 04260 207-657-4325 Raymond Psonak DO

Authorization to Consent to Medical Care and Treatment of a Minor

I, ____, am the biological or adoptive parent or

legal guardian of _________________________________, born on __________________

I hereby authorize Dr. Raymond Psonak of Chelation Medical Center, LLC, to make healthcare decisions pertaining to my child, named above, and providing consent for necessary evaluation (office visit), lab services, x-ray examination, or other office procedures. I also authorize the above named patient, to consent to ordinary medical care and treatment. Any healthcare provider relying upon this consent for the specified care and treatment of my child, named above, may do so to the same extent and in the same manner as if I had personally consented to such care or treatment. This Authorization may be withdrawn only in writing and shall not be deemed withdrawn until such time as my child's health care providers receive actual notice that I have withdrawn my consent as stated above.

This Authorization shall remain in effect until revoked in writing by the undersigned.

_____________________________ ________ ______________________ ________
Parent or Legal Guardian's Signature Date Witness's Signature Date

____
Parent or Legal Guardian's Printed Name

__________________________________ _______________ _______ ________
Street Address City State Zip

__________________________ _________________________
Daytime Phone Cell Phone

For Clinic Purposes Only: