NY SPINE CARE
INTERVENTIONAL PAIN MANAGEMENT
188-16 Northern Blvd
Flushing, NY 11358
Office: (718) 762-7000
Fax: (718) 762-7002

AUTHORIZATION OF CONSENT TO TREAT A MINOR

PATIENT NAME: _____ DOB: _____
(name of child) (child's date of birth)

SOCIAL SECURITY NUMBER: _____ PHONE NUMBER: _____
(child's ssn)

ADDRESS: _____
(street) (city/state/zip code)

I, _____, do hereby state that I am the parent/legal guardian of _____,
(name of parent/guardian) (name of child)
and give authorization to **Dr. Ji Han, M.D.** to consent to any necessary examination, medical treatment, and/or hospital care to be rendered to the above-named minor under the general or specific supervision of any physician or surgeon licensed under the provision of the Medical Practice Act.

_____ _____ _____
Parent/Guardian Signature | Parent/Guardian Contact Number | Date

_____ _____ _____
Witness Signature | Witness Name (please print) | Date