

**ACKNOWLEDGMENT OF RECEIPT OF
MINORS AND CONSENT TO TREATMENT BROCHURE**

I, _____, acknowledge that I have received the Rights of Minors to Health Care brochure. I was given the opportunity to discuss its contents and ask questions with my health care provider and staff.

Printed Patient Name

Date of Birth

Patient Signature

Date

Parent/Guardian Printed Name

Parent/Guardian Signature

Witness (Office Staff)

Date

**Parental/guardian signature is only required if care for the minor patient is sought directly by the parent(s)/guardian(s).