SMIL MEDICAL IMAGING
AFFILIATED WITH SOUTHWEST DIAGNOSTIC IMAGING LTD.

Scottsdale Medical Imaging

(An Affiliate of Southwest Diagnostic Imaging, Ltd.)

Consent to Treat a Minor

As the parent or guardian of _____, I am granting the person(s)
(Print Child's Full Name)

listed below permission to bring my child in for treatment and/or care on _____.
(Date of Visit)

The below person(s) will be permitted to approve any additional treatment needed during this visit, fill out all necessary paperwork (including the Financial Policy) and will have access to all medical information required for the treatment of my child during this visit.

Please list person(s) here	**Relationship**
_____	_____
_____	_____
_____	_____

_____ _____
Parent/Guardian Signature Date

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