

**DR. ROGER NORRIS**  
**621 Southpark Dr., Suite 1900**  
**Littleton, CO 80120**  
**(303) 797-2122**

**AUTHORIZATION TO TREAT A MINOR**

(We), the undersigned, parent(s), person having legal custody / guardianship of \_\_\_\_\_, a minor, do hereby authorize Dr. Roger Norris, D.C. to perform any chiropractic diagnosis or treatment which is deemed advisable.

It is understood that this authorization is given in advance and shall remain effective unless revoked in writing to Dr. Norris.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

(Parent/Legal Guardian/Legal Custody)