



Health Center of Integrated Therapies

A SERVICE OF LONGMONT UNITED HOSPITAL

1551 Professional Lane, Suite 125 Longmont, CO 80501
Phone (303) 651-5188 Fax (720) 494-4741

AUTHORIZATION TO CONSENT TO TREATMENT OF UNEMANCIPATED MINOR

Patient Name: _____ Date of Birth: _____

I, the undersigned, parent or guardian of _____, a minor
(Date of Birth _____) do hereby authorize therapists at Health Center of
Integrated Therapies in Longmont, Colorado to perform
_____.

This authorization expires after the episode or series of treatments but no longer than twelve
(12) months after today's date: _____.

Parent or Legal Guardian

Address

Telephone