

David Gilboe and Associates, Inc  
23161 Greater Mack Ave  
Saint Clair Shores, MI 48080  
(586) 779-8892

RELEASE FOR MINOR'S PHYSICAL THERAPY TREATMENTS

I, \_\_\_\_\_ hereby grant permission for  
Parent or Legal Guardian

My minor child, \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

to be treated at David Gilboe and Associates, Inc. under a prescription from

\_\_\_\_\_  
Physician's Name

for treatment of \_\_\_\_\_  
Diagnosis

The therapy has been explained to me, and I understand the treatment and explanation.  
(please initial after evaluation) \_\_\_\_\_

\*\*\*A stepparent or other adult cannot sign this document unless they have been legally  
appointed as the minor's guardian.

\_\_\_\_\_  
Parent/Guardian Signature Date

\_\_\_\_\_  
Witness Signature Date