



Michelle M. Mulder, M.D.

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Phone (928) 367-1444

Consent to Treat a Minor

Patient Name: _____

Custodial Adult / Parent Name: _____

I, _____, do hereby give consent for Michelle Mulder, M.D. or their designee, to examine and/or treat my minor child _____.
This includes breast, pelvic, ultrasound exam(s), and/or labs as indicated. Any treatments would be further discussed with the parent prior to treatment. This consent will remain in effect unless revoked in writing.

Signature of custodial adult / parent

Date

Witness

Date