Consent Form

I _____, authorize Dr. Michael R. Coppe, Dr. Carolyn Coppe and our staff to disclose any treatment needs and financial obligations with:

_____ _____

(Parent Name) (Parent Name)

□ I do not authorize Dr. Michael R.Coppe, Dr. Carolyn Coppe and staff to disclose any treatment needs and financial obligations with my parents.

_____ ____/_____/_____

(Print Name) (Date)

_____ ____/____/_____

(Signature) (Date)