

SUFFOLK BEHAVIORAL MEDICINE P.C.

Mulchand Chugh, MD
535 Broad Hollow Road, Suite # B-12
Melville, NY 11747
Tel # 631-513-6262

PERMISSION TO TREAT A MINOR

Date: _____

Name of Minor: _____

Address: _____

Date of Birth: _____

I hereby give permission for the above named minor whom I am responsible to be treated at the 535 Broad Hollow Road, Suite # B-12 Melville, NY 11747 under the care of Mulchand Chugh, MD or Suffolk Behavioral Medicine P.C.

Signature of Parent or Legal Guardian: _____

PrintName: _____

Address: _____