Advance Consent to Treat a Minor Patient

I, ___________________________________ (name of responsible party), hereby authorize all dermatology treatment deemed necessary by Dr. Sarah E. Dick.

Name of Patient: ______________________________________

Date of Birth: ____

Madrona Dermatology may provide treatment if my child is unaccompanied to his or her appointment, or if my child is accompanied by someone other than myself.

____

Signature of Responsible Party (Parent/Legal Guardian)

____ ________________________

Name (Printed) Date

____ ________________________

Relationship to Patient Witness Signature