Consent for Treatment of Minor Child:

Patient Name: ______________________________ Date of Birth: _____________________

I, being the parent or guardian of _____________________________________ , do hereby request and authorize the physicians and staff of Dermatology and Mohs Surgery Center, PC, to perform necessary services for my child which are deemed advisable by the physician, whether or not I am present at the actual appointment.

A parent/guardian who brings a child to our office for medical care is responsible for payment of all of the child's charges.

Below is the list of individuals who have permission to bring my child for treatment:

____ ___________________

Signature of Parent or Guardian Date

____ ___________________

Witness Date

THIS FORM SHOULD BE WITNESSED BY A MEMBER OF THE *DERMATOLOGY AND MOHS SURGERY CENTER, PC* STAFF.