ART OF DERMATOLOGY
MEDICAL • SURGICAL • COSMETIC

**Consent for Treatment of a Minor Child at Art of Dermatology PLLC**

I, being the parent / legal guardian of ______________________________________________
do hereby request and authorize the physicians/staff of Art of Dermatology PLLC to perform necessary services for my child, which are deemed advisable by the physician; whether or not I am present at the actual appointment.

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

| Name | Relationship |
| --- | --- |
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*This form should be witnessed by a member of the Art of Dermatology staff. If you are unable to accompany your child to his/her initial appointment, your signature must be notarized.

________________________________________ ______________
Signature of Parent or Legal Guardian Date

________________________________________ ______________
Witness Date