



# SOUTHLAKE DERMATOLOGY

1170 N. CARROLL AVE. SOUTHLAKE, TX 76092

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MAIN 817-251-6500 FAX 817-442-0550

## Minor Consent to Treat

I hereby authorize Dr. Angela Bowers, Dr. Sara Greer, Beth Palazzetti, PA, Cheryl Hickey, PA and any or other healthcare providers at Southlake Dermatology to treat my child \_\_\_\_\_ today and when I am not present. If a surgical procedure needs to be performed for any condition other than acne and warts, I will be contacted beforehand. I hereby acknowledge that all my questions have been answered about this formality and agree to this consent.

\_\_\_\_\_  
Parent or Guardian (Printed)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent or Guardian (Signature)

\_\_\_\_\_  
Witness