

Minor Consent to Treat

I hereby authorize Dr. Angela Bowers, Dr. Jill Feetham, 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