CONSENT FOR TREATMENT OF A MINOR IN THE ABSENCE OF A PARENT/GUARDIAN

Name of Minor Patient

Patient's Date of Birth

I, _____ ,
(Name of Parent or Guardian)

authorize The Dermatology Center at Ladera and its Affiliated Providers to provide dermatology medical treatment as deemed necessary by their provider for the minor patient listed above.

This authorization is valid until revoked in writing by me.

Signature of Parent or Guardian

Date