SPENCER DERMATOLOGY

SKIN SURGERY CENTER

CONSENT FOR EVALUATION AND TREATMENT OF A MINOR

I, ____ (primary parent or legal guardian) give permission for the minor child, ________________________________, to be examined and treated in my absence, as deemed necessary by a practitioner at Spencer Dermatology & Skin Surgery Center.

As the parent or guardian authorizing treatment, I also understand that I am the guarantor and I am solely responsible for the charges incurred.

____	___________________
Parent/Legal Guardian's printed name	Phone Number
____	___________________
Signature of Parent or Legal Guardian	Date

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