LAM DERMATOLOGY +ASSOCIATES

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AUTHORIZATION FOR TREATMENT OF A MINOR

Patient's name:_____ Date of Birth:_____

Legal guardian:_____ Relationship to patient:_____

Option One:

I, _____, give consent for the minor,

_____, to be seen without my presence and make their own medical decisions.

Option Two:

I,_____, give permission to _____, to act as my

representative and make the medical decisions for _____.

_____ For this date only

_____ For all appointments

_____ _____

Signature Date