GAINESVILLE DERMATOLOGY
medical + surgical + cosmetic

CONSENT FOR TREATMENT OF A MINOR

I, _____(Parent or Guardian) give permission for the minor child, _____, to be examined and treated for all visits, as deemed necessary, by a physician at Gainesville Dermatology and Skin Surgery.

As the parent or guardian, authorizing treatment, I understand that I am the guarantor and am solely responsible for the bill of the minor child.

_____

Signature of Parent or Legal Guardian

_____

Date

_____

Relationship