



Eastside Dermatology
& Skin Care Center

www.EastsideDermatology.com

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Consent for Treatment of a Minor

Patient Name _____

Patient's Date of Birth ____/____/____ Chart Number _____

I, _____, hereby authorize Eastside Dermatology & Skin Care
Parent/Legal Guardian

Centers providers to provide routine medical services for the above patient for the following condition:

_____ .

Routine care does not include invasive procedures or other treatments which are unusual or carry significant risk to the patient.

This consent is only valid for following dates: _____ until
Today's Date

No longer than one year from date signed

This consent can only be changed with written notification by the parent/legal guardian.

Name _____ Phone _____
Parent/Legal Guardian

Signature _____ Date _____
Parent/Legal Guardian