CASTLE ROCK DERMATOLOGY, PC

Amy Broomer, DO

AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR CHILD

I, _____(parent or legal guardian), being the parent or legal guardian of _____(Minor's name), give my permission for treatment by the doctor or other medical providers at Castle Rock Dermatology. The minor named in this consent document may receive all treatment provided according to generally accepted standards of medical practice.

My consent is effective for the period of _____ through _____

_____ _____

Signature of Parent or Guardian Date

NOTE: If there are any special parental or custodial relationships (such as custody with one parent only, legal custody/guardianship with non-parent, etc) please explain in the space below with your signature, printed name, and phone number at which you can be contacted.

_____

_____

_____

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