CASTLE ROCK DERMATOLOGY, PC

Amy Broomer, DO

MEDICAL POWER OF ATTORNEY AUTHORIZATION FOR MEDICAL TREATMENT

I, _____(Print your name), being the medical power of attorney for _____(Print patient's name), give my permission for treatment by Dr. Broomer or other medical providers at Castle Rock Dermatology. The patient 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 Medical Power of Attorney Date

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