MRN:_________________________
(*Office use*)

Patient: ___________________________ Date of Birth: _______________________

Central Missouri Dermatology Associates, LLP

CONSENT TO TREAT:

I ______________________________________ (parent or legal guardian) give my permission for the providers at Central Missouri Dermatology to treat ___________________________________ (patient).

The patient is being accompanied today by his/her: ______________________________________ (grandfather, grandmother, brother, sister, aunt, uncle, step parent etc.)

I can, in writing, remove this authorization at any time.

Sign: ____ Date: __________________

Relationship to patient: ______________________________ (must be parent or legal guardian)