CORONADO DERMATOLOGY

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CONSENT TO TREAT MINOR

I_____ give permission
(parent or guardian)

to_____for treatment of _____,
(provider) (patient)

without a parent or guardian present.

This includes the prescribing of any medications, without the need to call a parent or guardian prior to each visit.

SIGNATURE:_____ DATE:_____

WITNESSES BY:_____ DATE:_____

*Valid 1 year past date of signature