Southlake Dermatology

431 E. State Hwy 114, Suite 300
Southlake, TX 76092
Main 817.251.6500 Fax 817.442.0550

Minor Consent to Treat

I hereby authorize Dr. Angela Bowers, Beth Palazzetti, PA, Cheryl Hickey, PA, Meredith Revell, PA and any or other healthcare providers at Southlake Dermatology to treat my child _____ today and when I am not present. If a surgical procedure needs to be performed for any condition other than acne and warts, I will be contacted beforehand. I hereby acknowledge that all my questions have been answered about this formality and agree to this consent.

_____ _____

Parent or Guardian (Printed) Date

_____ _____

Parent or Guardian (Signature) Witness