

WEST BLOOMFIELD DERMATOLOGY  
6900 ORCHARD LAKE RD, SUITE 209  
WEST BLOOMFIELD, MI 48322  
PHONE 248-855-7500  
FAX 248-855-7461

**CONSENT TO TREAT A MINOR**

This form authorizes the evaluation and treatment of your child in your absence.

I, \_\_\_\_\_, authorize Dr. Mohammadi and/or Dr. Watnick  
to evaluate and treat \_\_\_\_\_, in my absence.

This authorization is valid for dates of service \_\_\_\_\_ to \_\_\_\_\_.

Parent/legal guardian signature \_\_\_\_\_  
Date \_\_\_\_\_

Doctors signature \_\_\_\_\_.