WEST BLOOMFIELD
DERMATOLOGY AND MOHS SURGERY

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CONSENT TO TREAT A MINOR

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

I, (print name of parent/guardian)_____,

authorize Dr. Watnick, Dr. Mohammadi, and/or Dr. Sklar to evaluate and treat

(print patient name)_____ in my absence.

This authorization is valid for dates of service _____ to _____.

X_____
Parent / legal guardian signature Date

X_____
Doctor / Office staff signature Date