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, _____, authorize Dr. Sklar, Dr. Mohammadi, Dr. Hwang, Dr. Shabeeb,
(print name of parent/guardian)

and/or Daniel Tomlinson, NP to evaluate and treat _____ in my absence.
(print patient name)

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

X_____ _____
(parent/legal guardian signature) (date)

X_____ _____
(witness signature) (date)