davidson
DERMATOLOGY

Consent of Treatment of Minor

I authorize, Dr. Davidson, Dr. Amrhein, or Ellen Matteson, PA-C to examine, diagnose and treat my child, _____ , at his/her discretion in the event that I am unable to accompany my child on subsequent office visits. I am financially responsible for the treatment of this patient and will remit payment to Davidson Dermatology with visit.

Signature_____

Date _____