

Dermatology of Seattle
13610 First Avenue South, Seattle, WA 98168
206-248-5020 – 206-244-8425 (fax)

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. Elie Levy, and whomever may be designated as his assistants, to administer care as is deemed necessary to my _____ (relationship of child.)

CHILD'S NAME: _____

ADDRESS: _____

CITY, STATE: _____ ZIP: _____

Signature of Parent or Guardian

____/____/____
Date

Signature of Witness

____/____/____
Date