

Northwest Skin Specialists, PLLC

ADVANCE CONSENT to TREAT MINORS

Patient Name: _____ **DOB:** _____

I, _____, the parent or legal guardian of the above listed patient, authorize and consent to routine and emergency medical treatment for him/her when deemed necessary by qualified medical personnel. This authorization will be in effect until revoked in writing by me.

Signature of parent/legal guardian

Phone#

Date