Consent for Treatment of Minor

I authorize Dr. Lesly Davidson or Melissa Loeffler, 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 the visit.

Signature: _____

Date: _____

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