



SPECTRUM
DERMATOLOGY OF SEATTLE

**ADVANCED CONSENT TO
TREAT A MINOR PATIENT**

Today's Date _____

I, _____ (Name of Responsible Party), hereby authorize all dermatology treatment deemed necessary by Dr Paula Zook.

Name of Patient: _____ Date of Birth: _____

Spectrum Dermatology of Seattle may provide treatment if my child is unaccompanied to his or her appointment, or if my child is accompanied by someone other than myself.

Signature of Responsible Party (parent / legal guardian)

Name (printed)

Date (month/day/year)

Relationship to Patient

Witness Signature