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