GOLDMAN DERMATOLOGY, PLLC
150 Broadway, Suite 1110
New York, NY 10038
212-962-1115

CONSENT TO TREAT A MINOR CHILD IN THE ABSENCE OF A PARENT OR GUARDIAN

I hereby authorize the physicians and/or physician assistants of Goldman Dermatology, PLLC, to treat my child in my absence.

Child's Name: _____

Child's Date of Birth: _____

Appointment Date: _____

I understand that a separate consent form must be duly executed for each appointment, and that this consent form is only valid for the appointment date entered above.

I understand that no surgical procedure will be performed without a duly executed consent form.

Parent/Guardian Signature: _____

Date: _____

Parent/Guardian Name (print): _____

Relationship to Patient: _____