For Patients Under 18 Years of Age

PARENT OR LEGAL GUARDIAN OF: ____

First _________________________ M.Initial ______ Last _______________________________

Address ____

City____State_____Zip__________________________

Home Phone____________________________ Day Phone_________________________

Date of Birth ____/____/____

Social Security#____________________________ Email ____

Employer____ _______________

Relationship to patient: (circle one) (a) Parent (b) Legal Guardian (c) Other_________________________

AUTHORIZATION TO TREAT MINOR. As either the natural parent or legal guardian of the above named patient, I authorize Puget Sound Dermatology physicians to evaluate and administer medical care to my minor child. In the case of my child aged 18 or older, consent to evaluate and administer medical care is granted in accordance with my child's personal request and need and physicians professional judgment.

SIGNED ____ DATE __________________________

Parent or Legal Guardian

21727 76th AVENUE WEST, SUITE H, EDMONDS, WASHINGTON 98026
Phone: (425) 672 1333 Fax: (425) 672-7755