Compassion
DERMATOLOGY

3065 W. Southlake Blvd., Suite 140
Southlake, TX 76092
Phone: 817.380.5911 / Fax: 817.385-6579
Website: compassiondermatology.com

Minor Consent to Treat

I hereby authorize Dr. Holly DeBuys or other healthcare providers at Compassion Dermatology to treat my child ____ when I am not present. If a surgical procedure needs to be performed for any condition other than acne and warts, I will be contacted beforehand. I hereby acknowledge that all my questions have been answered about this formality and agree to this consent. This consent will stay active until we are notified in writing to remove this consent to treat.

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Parent or Legal Guardian (Printed)

____ __________________

Parent or Legal Guardian (Signature) Date