Aesthetic and General
Dermatology OF Seattle
Elie Levy MD & Associates
13610 First Avenue South
Burien, WA 98168

CONSENT TO TREATMENT OF MINOR CHILD

I hereby authorize Dr. Elie Levy, and whomever may be designated as his assistants, to administer care as is deemed necessary to my _____ (relationship of child.)

CHILD'S NAME: _____

ADDRESS: _____

CITY, STATE: _____ZIP: _____

_____ _____/_____/_____
Signature of Parent or Guardian Date

_____ _____/_____/_____
Signature of Witness Date