MAGNOLIA
DERMATOLOGY

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Authorization to Treat Minor

I authorize Dr. Myers to examine, diagnose, and treat my child, _____ DOB _____, at his/her discretion in the event that I am unable to accompany my child on subsequent office visits. I am financially responsible for the treatment of their patient and will remit payment to Magnolia Dermatology.

_____ _____

Signature/ Relationship Telephone Number

_____ _____

Signature of Provider or Physician Date