TWIN PEAKS DERMATOLOGY, PC

JOHN FUESTON, MD

DIPLOMATE AMERICAN BOARD OF DERMATOLOGY FELLOW AMERICAN ACADEMY OF DERMATOLOGY

AUTHORIZATION FOR MEDICAL TREATMENT OF A MINOR CHILD

I, _____(parent or legal guardian), being the parent or legal guardian of _____(Minor's name), give my permission for treatment by the doctors or other medical providers at Twin Peaks Dermatology. The minor named in this consent document may receive all treatment provided according to generally accepted standards of medical practice.

My consent is effective for the period of _____through_____

_____ _____

Signature of Parent of Guardian Date

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