TWIN PEAKS DERMATOLOGY, PC

JOHN FUESTON, MD

DIPLOMATE AMERICAN BOARD OF DERMATOLOGY   FELLOW AMERICAN ACADEMY OF DERMATOLOGY

Medical Power of Attorney Authorization for Medical Treatment

I, _______________________________________(print your name), being the medical power of attorney for ______________________________________(print patient's name), give my permission for treatment by the doctors or other medical providers at Twin Peaks Dermatology. The patient 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 Medical Power of Attorney   Date

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