DERMATOLOGY & CUTANEOUS SURGERY, INC.
MICHAEL E. MCCADDEN, M.D., F.A.A.D.
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CONSENT FOR TREATMENT OF A MINOR

Patient name:_________________________ Date of Birth:________ Today's date_________

I, the undersigned parent/guardian of ________________________, a minor, do hereby authorize and direct Michael E. McCadden, MD, Lisa Burgard, FNP, and the staff of Dermatology and Cutaneous Surgery, Inc. to provide dermatologic-related healthcare services. This consent shall remain in effect until the minor child turns 18, or until revoked in writing. I authorize ______________________ to consent to any dermatologic treatment advised by Dr. Michael E. McCadden, MD, or Lisa Burgard, FNP in my absence.

____________________ ____________________ ________________ __________
Name Signature Relationship Date

______________________ ____________
Witness Date

Telephone Consent

1. Consent by telephone may be obtained when treatment is needed or desirable if if an adult patient is unable to give consent, or the patient is a minor.
2. Telephone consents require two witnesses.
3. Whenever possible, telephone consents should be followed up with a signature or fax. The fax should be attached.

______________________ __________________ ________________ __________
Name Relationship Telephone Date

___________________ __________ ____________________ __________
Witness Date Witness Date