LAING DERMATOLOGY & SKIN CANCER CENTER, PA
6807 Knightdale Blvd., Suite C
Knightdale, NC 27545
Office: 919 217-5510

Treatment of Minors

I,_____, give my consent for the following minor child
(please print)
Patient Name_____DOB_____to be seen and treated by Laing Dermatology & Skin Cancer Center, PA. I have the legal right to delegate such consent. Unless specifically expressed otherwise this consent includes the consent to perform minor surgical procedures including but not limited to skin biopsy, skin excision, acne surgery, acne topical treatment including the application of peeling agents, the prescribing &/or dispensing of prescription and non prescription medications. I understand and agree that I am liable for any and all charges incurred by the treatment of the above patient.
Limitations on such consent and treatment are as follows (if none write none)

_____.

This consent has the following time limitations (if none write none):

_____.

CONTACT INFORMATION (please print)

Parent's Name: _____ Daytime Phone:_____.

Evening Phone: _____. Cell Phone:_____.

Parent's Name: _____ Daytime Phone:_____.

Evening Phone: _____. Cell Phone:_____.

Signature of Parent or LegalGuardian_____DATE:_____

Signature of Witness:_____DATE:_____