The Dermatology Practice of
Bruce P. Robinson, M.D., F.A.A.D.
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CONSENT TO TREAT A MINOR

Patient's Name _____

I, _____, give my consent to the providers at The
Parent / Guardian Name

Dermatology Practice of Bruce P. Robinson, M.D. to treat _____
Patient Name

In my absence. I understand that this consent takes effect today and will continue until

_____.
Please Specify a Date or Write Indefinitely

This consent is for evaluation and medical treatment including administration of local anesthetic if determined by a physician to be necessary, unless otherwise stated below:

CHECK APPLICABLE BOX

☐ The minor above may be seen and treated in the office without parent or guardian present.

☐ The minor above may be seen and treated in the office when accompanied by:

_____

Print Name: _____

Relationship to minor: _____

Signature: _____