Authorization For Treatment of a Minor

Patient Name: ____

Date of Birth: ____

I, the undersigned parent/legal guardian, of the minor person listed above do authorize the physicians: Dr. Alan Levy, Dr. Danielle Levine, Dr. Joshua Cash, Dr. Alexander Hicks, and Dr. Matthew C. Gordon and Advanced Practice Providers (APP) Lauren Plyler, NP, Dallas Provence, NP, Jade Wilkie, NP, Megan Cody, NP, Madga Shapaker, NP, Jessica Zarshenas, NP, Barry Flippo, PA-C, Jodi Burgess, PA-C, Susannah Cash, PA-C, Kelly Johnston, PA-C and their assistants of Levy Dermatology, P.C. to provide health services to this minor in the absence of a parent or legal guardian. These health services may include, but are not limited to examination, preventative and/or curative treatment, laboratory examination, anesthetic, medical or surgical diagnosis and any consultation deemed necessary at the physician's discretion. Services shall not include research.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required and is given to encourage and allow the physician and/or APP to exercise his/her best judgement as to the requirements of such diagnosis or medical treatment in my absence.

This consent shall remain in effect until revoked, in writing, by a parent or legal guardian or until the child may legally consent for him or herself.

Signature of Parent or Legal Guardian: ____

Date: ____

Witness Signature: ____

Witness Name: ____

Date: ____

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