



ADVANCED SCIENCE FOR BEAUTIFUL SKIN
MGMD Dermatology ■ Michele Grodberg MD

MINOR PATIENT RELEASE FORM

I, _____ Hereby give Dr. Grodberg and her medical personnel permission to treat my minor child as deemed necessary during my absence.

NAME OF CHILD _____

DATE OF BIRTH _____

In case of emergency, please contact

Name(print) _____ Relationship _____

Phone # _____ Date _____

Signature _____ **Date** _____

Relationship to patient: parent or guardian

Witness: _____ **Date** _____