Glynis Ablon, MD, FAAD
Associate Clinical Professor UCLA
Ablon Skin Institute
1600 Rosecrans Ave. Building 4B
Manhattan Beach, CA. 90266
310-727-3376

Patient's Name: _____

Date of Birth: _____

Family Doctor: _____

Allergies: _____

Authorization for Consent to Treatment of Minor

(I,We), the undersigned, parent(s) of _____, a minor, do hereby authorize _____ as agent(s) for the undersigned to consent to any examination, anesthetic, medical, or surgical diagnosis or treatment which is deemed advisable by, and is rendered under, the general or specific supervision of Dr. Ablon licensed under the provisions of the Medical Practice Act on the staff of the Ablon Skin Institute.

It is understood that this authorization is given in advance of any specific diagnosis treatment, being required, and is given to provide authority and poser on the part of my (our) treatment which Dr. Ablon, in the exercise of her best judgment, may deem advisable.

This authorization is given pursuant to the provisions of Sect 25.8 of the Civil Code of the State of California.

This authorization shall remain effective until_____, 20_____, unless sooner revoked in writing and delivered to said agent(s).

Please provide a credit card number to be used for services on the day of the minors treatment
Credit Card #_____ Exp Date_____ Billing Zip code____

_____ Dated

_____ Father

_____ Witness

_____ Mother

_____ Legal Guardian