Date: ___________________________

To McLean Dermatology & Skincare Center:

Patient Name:	
Patient Date of Birth:	

____ has my permission to make medical decisions and receive medical information on my behalf for the above mentioned patient for the date of service: _________________________ at McLean Dermatology and Skincare Center.

Please note person must show Government Issued ID when presenting patient at McLean Dermatology & Skincare Center.

Sincerely,

Printed Name　　　　　　　　　　　　　　　　　Relationship to Patient

Signature of Parent or Legal Guardian　　　　　　　　　　　　Date Signed

6849 Old Dominion Dr. Suite 340 McLean VA phone: 703.356.5111 fax: 703.388.0873
www.mcleandermatologycenter.com facebook.com/mcleandermatology askdrlily.blogspot.com