



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. Julie Jefferson, Dr. Meredith Wagner, and Dr. Josh Cash and Advanced Practice Providers (APP) Lauren Plyler, NP, Dallas Provence, NP, Jade Wilkie, NP, Barry Flippo, PA-C, Jodi Burgess, PA-C, Megan Philips, PA-C, Susannah Cash, PA-C, Denise Shepler, PA-C, and Kelly Johnston, PA-C and their assistants of Levy Dermatology, P.C. to provide health services to this minor in 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 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: _____

Levy Dermatology, P.C
6254 Poplar Avenue
Memphis, TN 38119

Levy Dermatology, P.C
1125 Schilling Blvd E, Suite 105
Collierville, TN 38017

Levy Dermatology, P.C
15 Old Humboldt Road, Suite A
Jackson, TN 38305