OZARK DERMATOLOGY

Fayetteville: 479.443.5100 Fax: 479.443.5117
Bentonville: 479.273.7006 Fax: 479.273.9497
Siloam Springs: 479.373.6566 Fax: 479.373.6567
Lowell: 479.347.2700 Fax: 479.347.2701

AUTHORIZATION TO TREAT MINOR

Name of Patient: _____ DOB: _____

I, _____ give permission for medical treatment to the m
listed above. If for any reason, the course of treatment changes or if there is a request by the minor to treat something other than the course of treatment for an ongoing condition, I agree to be contacted by the provider for discussion.

Signature of parent or guardian:_____

Relationship to patient: _____

Phone number: _____

Date: _____

Kevin St. Clair, M.D. Chris Schach, M.D. Eric Stewart, M.D. Jamie Abbott, M.D. Scott Jackson, M.D. Stephen Hughes, M.D. Robert Stevens, PA-C
Joshua Matthews, PA-C Kristy Walker, PA-C Mary Susan Hilton, PA-C Janelle Claborn, PA-C Karlee Van Dam, PA-C Danielle Willams, APRN