COSMETIC SURGERY & DERMATOLOGY OF ISSAQUAH, INC.
VICTOR R. MICHALAK, M.D.

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CONSENT TO TREAT MINORS

I, _____, the parent or legal guardian of my child, _____, authorize and consent to medical treatment and procedures to be performed for my child by Dr. Michalak or his physician assistants, aesthetician when deemed necessary or advisable by Dr. Michalak or the above medical personnel. It may include services such as biopsy, acne surgery, laser treatment, pathology and or laboratory charges (second opinions) if necessary as may be determined to be in the best interest of this member of my family who is a minor. This authorization shall continue and be in full force and effect until revoked in writing by me.

Parent/Guardian signature _____

Date _____

Witness _____