

Fairlawn Dermatology, LLC.

I _____ (full name) being the parent/guardian of _____ (child's full name) give permission for my child to be seen in the office without a parent or guardian present. I authorize the provider(s) to make necessary changes to medications and/or perform minor procedures, such as cryosurgery, acne chemical peels, and necessary biopsies.

This authorization will remain in effect until the child's 18th birthday or revoked by a parent/guardian.