HIGH TIDE DERMATOLOGY CENTER

Debra L. Bailey, M.D.

Parental Consent to Treatment of a Minor

(I)(WE), the undersigned, parent(s) of _____, hereinafter "Minor" do hereby grant permission to the High Tide Dermatology Center to treat in (my) (our) absence for any medical or surgical diagnosis or treatment which is deemed advisable by, and is rendered under the general or specific supervision of any physician, when such medical or surgical diagnosis or treatment is rendered at the office, located at 2350 Vanderbilt Beach Road, Suite 301, Naples, FL 34109.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or care being required, to grant consent for treatment to the aforementioned minor is (my) (our) absence.

This authorization shall remain in effect:

□ through the _____ day of _____, 20_____.

□ until age 18

Parent: _____ Date _____

Signature

Parent: _____ Date _____

Signature

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