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Patient Name _____ Account Number _____

I, _____, _____, of _____, give
(Parent or guardian name) (Relationship to patient) (Patient's Name)

Brevard Skin & Cancer Center consent to evaluate and/or treat _____,
(Patient's Name)

as necessary. Patient does not have to be occupied by parent/guardian to be seen by Brevard Skin & Cancer Center. I understand that it is still up to the provider's discretion to refuse to treat this patient if a change in treatment is necessary. This form will not apply to the patient's initial visit. All patients must have patient or guardian present for any initial visit.

Signature _____ Date _____
(Parent or guardian signature)

Witness _____ Date _____

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