

**Dermatology Associates of Central Texas**  
**1809 SW HK Dodgen Loop Suite 100**  
**Temple, Texas 76502**

**MINOR CONSENT**

I, \_\_\_\_\_, hereby authorize Dermatology Associates of Central Texas to treat my minor dependant, \_\_\_\_\_ in my presence or unaccompanied.

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_