

The Dermatology Institute of South Texas
Charmaine F. Browne, M.D., P.A.

3330 N. McColl Rd., Suite 102
McAllen, TX 78501

Phone:(956) 661-0500
Fax: (956) 661-0510

Minor (Patient) Information

Full Legal Name of Minor: _____

Date of Birth: ___ / ___ / ____

Person Giving Consent

Full Name: _____

Relationship to Minor (check all that apply):

- Parent
 Legal Guardian / Managing Conservator
 Grandparent
 Adult Brother or Sister
 Adult Aunt or Uncle
 Adult with Written Authorization from Parent/Guardian (attach copy)
 Other (explain): _____

Phone Number: _____

Email Address: _____

Authorization for Dermatologic Treatment

I authorize **Dr. Charmaine Browne and staff** to evaluate, diagnose, and treat the minor named above for **dermatologic care**, including but not limited to:

- Office visits and skin examinations
- Diagnostic procedures (including skin biopsies)
- Medical and minor surgical dermatologic treatments
- Prescription and administration of medications
- Follow-up care related to the above services

Limitations (if any):

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