Castle Rock Dermatology, PC

755 Maleta Lane, Suite 201

Castle Rock, CO 80108

(303)688-6355 fax (303)688-6876

Dr. Broomer has permission to evaluate and treat my child, today and in the future, without my presence.

Child's Name:_____

Child's Date of Birth:_____

Signature:_____

Relationship to Child:_____

Date:_____

NOTE: If there are any special parental or custodial relationships (such as custody with one parent only, legal custody/guardianship with non-parent, etc.) please explain in the space below with your signature, printed name, and phone number at which you can be contacted.