METRO DERMATOLOGY

2175 Lemoine Ave, 6th Floor, Fort Lee, NJ 07024 T: (201)886-9000 F: (201)227-1789
144-72 Northern Blvd, Suite 203, Flushing, NY 11354 T: (718)886-9000 F: (718)961-0666
220 E 161ST Street Ground Floor, NY 10451 T: (718)292-9197 F: (718)292-4429
40-12 80TH Street, Elmhurst, NY 11373 T: (718)886-9000 F: (718)961-0666

Authorization for Evaluation and Treatment of a Minor Unaccompanied by Parent or Legal Guardian

The undersigned, hereby authorized and give consent to all Metro Dermatology providers:

Hyun-Soo Lee, M.D.	***Diana Sun, M.D.***	***Stephanie Hu, M.D.***
Charles Kwak, M.D.	***Carey Kim, M.D.***	***Hanna Park, NP-C***
Stacy Li, PA-C	***Yu Jin Kim, PA-C***	***Christine Chen, PA-C***
Samantha Hussain, PA-C	***Sujin Kim, PA-C***	***David Shin, PA-C***
Curtis Chen, PA-C		

to see my Child, _____, Date of Birth_____
a minor, for medical evaluation and treatment for six(6) months from the undersigned date.
I understood I am still financially responsible for all medical expenses incurred by my child during these appointments.
The insurance of this authorization may be used for whatever legal purposes it may serve.

Print Name and signed _____
Parents/Legal Guardian

Date: _____