CAUDILL, KADO & CO

DERMATOLOGY

Date:_____

Pt: Name_____

Address:_____

Caudill, Kado & Co.
5885 S. Main St. Suite 1
Clarkston, MI 48346

Dear Dr. Caudill and associates,

I hereby give my permission for my daughter/son, _____ to obtain medical treatment from all medical staff associated with your practice, even in the absence of a parent, beginning today and continuing for one year.

I accept financial responsibility for any charges incurred during said treatment. I can be contacted at this #_____ if any further questions or concerns arise.

Thank you,

Parent/Guardian_____