MADFES AESTHETIC MEDICAL CENTER

ONE EAST SIXTY- NINTH STREET
NEW YORK, NEW YORK 10021

PHONE (212) 249-8118
FAX (212) 249-8884

CONSENT TO TREAT A MINOR

By signing below, I _____ parent/guardian of

_____, give permission to Dr. Diane Madfes and

Dr. Esther Williams to treat my child today and in the future.

This consent will be kept in my child's medical record.

Print Name:_____

Parent/guardian Signature:_____

Date:_____