

V. LIGHTNER FAMILY DERMATOLOGY
82 Wheaton Ave., Youngsville, NC 27596 (919) 562-8887

POA AUTHORIZATION

I, _____, the POA for
patient, _____, authorize Dr.
Virginia Lightner of V. Lightner Family Dermatology, to evaluate and treat said
patient in my absence. This authorization is valid until revoked in writing.

Please list any restrictions: _____

Signature of POA Date Signed

Witness Signature Date Signed

Print Name of Patient DOB

*Our office will need to have a copy of the POA documentation on file. Please provide us a copy of your legal document.