I hereby authorize my Patient, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to obtain a Dermfix UVB 6000B-T Ultraviolet Home Phototherapy Device for Psoriasis treatment. The Patient understands that they must read the instructions manual before using the device, and that they should undertake a skin examination at least once per year after commencing treatment.

Signed:

Date: