CENTER FOR DERMATOLOGY

MINOR CONSENT FOR MEDICAL CARE

The law requires that we obtain consent from the parent or legal guardian for patients under age 18 PRIOR to their receipt any medical treatment unaccompanied.

Patient Name _____Date of Birth _____

Parent/Legal Guardian Name _____ Date of Birth _____

Relationship to Patient _____

Contact Phone Number (phone calls only) _____

Address _____

I authorize _____ to go to appointments independently.

Minor Child Name

Center for Dermatology has my permission to provide medical care in my absence. Routine medical care may include but is not limited to medical evaluation, physical examination, prescribing medication, procedures and follow-up care for treatment. I understand that I am still financially responsible for all medical expenses incurred by my child during these appointments and that my child may need to complete and sign paperwork in my absence.

This authorization is valid until revoked in writing by the parent/legal guardian or until the patient turns age 18.

_____ _____

Parent or Legal Guardian Signature Date