Dermatology Professionals, PA

Authorization for Consent of Medical Treatment for Minors

Dermatology Professionals providers reserve the right to require parent / legal guardian to accompany minor child for certain treatments or appointments

Minor Patient Name:_____ Account:_____

In the event I (or my child's other parent / legal guardian) am not able to accompany my child to their medical appointment, I hereby authorize

Name:_____ Relationship to Minor:_____

Name:_____ Relationship to Minor:_____

the above named persons to be able to accompany my child to their appointment. I hereby authorize them the right to consent to any examination, treatment, medical diagnosis, to be rendered to the minor under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the state of Minnesota.

I do hereby release, indemnify and hold harmless all physicians and other persons who act in reliance upon this authorization.

Printed Name of Parent / Legal Guardian:_____

Signature:_____Date:_____

I permit a copy of this authorization to be used in the place of the original.

****The authorization will remain active until minor child reaches the age of 18 or until the authorization is revoked.**

Signature of Witness _____

I hereby revoke the above consent of authorization for treatment on the date of: _____

Printed Name of Parent / Legal Guardian:_____

Signature:_____Date:_____