TDC CONSENT FOR TREATMENT OF MINOR

Please note that a parent/legal guardian MUST be present for the initial appointment

I, being the parent or legal guardian of, _____ in my absence do hereby request and authorize The Dermatology Center, PLLC to administer care as necessary.

I authorize the person (s) listed below to consent to treatment of the child, including, but not limited to, emergency, x-ray, anesthetic, or surgical services when I am not immediately available in person.

It is understood that this consent is given in advance of any specific diagnosis or treatment and allows the physician/provider to diagnose and treat the child even when the parent or guardian is not present.

I understand that I am responsible for services rendered for treatment and payments authorized by my personal representatives. If I choose to terminate the authorization of this form, I understand I must do so in writing. I understand this form is valid one year from date signed.

Person (s) who may consent to treatment (please print):

Name:_____ Relationship:_____
Name:_____ Relationship:_____
Name:_____ Relationship:_____

Parent/Guardian Name: _____

Signature:_____Date:_____

Relationship to child: _____

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