AFFILIATED DERMATOLOGISTS

Consent for Medical Treatment of a Minor Child

*****Parent or Legal Guardian MUST accompany minor on first visits*****

Date: _____

Patient Name: _____

Patient Birthdate: _____

Appointment Date: _____

I authorize Affiliated Dermatologists and its clinicians to evaluate and treat my minor child for routine, non-urgent dermatology care related to established conditions (for example, acne) when I am not present, including follow-up visits and prescription management/refills, and related lab orders as clinically indicated. This authorization remains in effect until I revoke it in writing, or the child turns 18, whichever occurs first. Services that materially increase risk or are elective cosmetic in nature will require separate consent.

Parent or Legal Guardian's Telephone Number: _____

Parent or Legal Guardian's Signature: _____

Printed name of Parent or Legal Guardian: _____