PERMISSION TO ACCOMPANY A MINOR

Dermatology & Skin Surgery Center

210 Village Center Pkwy
Stockbridge, GA 30281
www.dermandskin.com
(770) 474-5952

Please sign at the bottom of form

I, ______________________________ give permission to the adult(s) listed below to accompany my child (name and DOB) ____ and authorize treatment for my child in accordance with the office policy of **Dermatology & Skin Surgery Center, PC.** This includes bringing the child into the office of **Dermatology & Skin Surgery Center, PC,** providing a history of present illness, disclosure of protected health information, accompanying consented research study procedures, and witnessing any physical exam completed by the provider. This adult has the responsibility to relay any diagnosis, treatment plan and/or prescriptions(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all copays and coinsurance.

This authorization is effective on: ________________________ and expires _____________________.

Name: ____

Name: ____

Name: ____

Emergency Contact Information for Parents/Guardians:

Where/how can you be reached in case of emergency? Phone ______________________________

Comments ____

Temporary Guardian Information Name: ____

Phone: ________________________ Address: ____

Relationship to the patient: ____

____ ________________________

Parent or Legal Guardian's Signature ***Date***