PERMISSION TO TREAT 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 the form

I, _____ give permission to treat my child_____ to attend his/her illness appointment alone without my presence and authorize treatment for my child in accordance with the office policy of **Dermatology & Skin Surgery Center, PC**. This includes providing a history of present illness, disclosure of protected health information (PHI), and responsibility for relaying any diagnosis, treatment plan, or prescription(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 _____.

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***