AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR AT CURRENT DERMATOLOGY, WHEN LEGAL GUARDIAN and/or PARENT(S) IS UNABLE TO BRING PATIENT (ID is required)

(Please print or type)

I, ____, as primary parent or guardian of ____, a minor, do hereby authorize the following person(s): a.____________________________________ b. ___________________________________ c. ___________________________________ as my agent(s) to consent to any evaluation, treatment recommendations and biopsy, if necessary, which is deemed advisable by and is to be rendered under, the general or special supervision of a licensed physician.

It is understood that this authorization is given to provide authority and power on the part of my aforesaid agent(s) to give specific consent to any and all evaluation, treatment recommendations and biopsy, if necessary, which a physician, in the exercise of his/her best judgment, may deem advisable. This authorization also grants to my agent(s) the power to sign for release of information to any third party payers who may be responsible for part or all of the cost of the services provided. This authorization shall remain effective from

Active dates for this consent: ______/______/_____ to _____/_____/_____ (Unless sooner revoked in writing delivered to Current Dermatology)

____ ________________________________

Signature of parent, guardian or other legal representative/Date

PATIENT INFORMATION FOR MINOR RECEIVING SERVICES AS LISTED ABOVE___________________

Patient's Name: ______________________________ Date of Birth: _____/_____/_____

Home Address:____

____

Current Medication(s):____

Allergies: ____

Parent or Guardian Name(s):

(1)____

Relationship______________________________________

(2)____

Relationship______________________________________

Primary Insurance Company: ____

Name of Policyholder: ____

Address (if different from above):____

____

Number:___________________________ Group Number:___________________

current DERMATOLOGY