

DERMATOLOGY CONSULTANTS, P.A.

Parental/Guardian’s Consent to Treat a Minor Accompanied by Another Adult

Many times parents find themselves unable to accompany their children to appointments. This form has been prepared for your convenience should you at some time have someone else accompany your minor children.

I give permission to _____

to consent to the treatment of my son/daughter _____

by any physician of Dermatology Consultants, P. A..

I also agree that test results and/or medical information may be released to the above-named adult.

Signature of Parent or Guardian

Date

This form expires in one year unless revoked in writing by the parent or guardian.

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Treatment to Unaccompanied Minors

Many times parents or guardians find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your minor.

I hereby grant Dermatology Consultants, P.A. permission to treat my child

_____ when they

arrive at the office unaccompanied.

Signature of Parent or Guardian

Date

This form expires in one year unless revoked in writing by the parent or guardian.