Authorization and Consent to Treat a Minor

*****If sending electronically please include a picture of parent/legal guardian identification*****

Without A Parent/Guardian Present

I, ___________________________ give permission for DeSilva Dermatology, its staff, doctors, and providers to treat
(Parent/Legal Guardian)
____________________________, ______/______/______ without a parent/legal guardian being present.
(Patient) *(DOB)*

I authorize DeSilva Dermatology to provide medical care to my son/daughter, including but not limited to, diagnostic examinations (including laboratory testing), treatment procedures, and prescribing of medications as deemed appropriate by his/her physician.

I understand that should my minor need more invasive diagnostic or surgical procedures, attempts will be made to contact me before such care is initiated.

I further understand that once my child reaches the age of maturity, my consent for treatment *is no longer required*.

This consent will remain in effect until the patient reaches the age of eighteen unless revoked in writing to DeSilva Dermatology.

Payment is expected the day of the appointment and can be made by cash, check or credit card or payment can be made in advance over the phone.

______________________________________ _________/_________/_________
Signature of Parent/Legal Guardian Date
Phone: ______________________ Mobile: _____________________ Work: ________________________

Appointing a Guardian to Accompany a Minor During Treatment

I, _______________________________ authorize and appoint______________________________, as my agent
(Parent/Legal Guardian) *(Person attending the visit)*
for my minor child, ______________________________________, ______/______/______ to DeSilva Dermatology
(Patient) *(DOB)*
For their medical visit. I understand the medical care may include but not limited to, diagnostic examinations (including laboratory testing), treatment procedures, and prescribing of medications as deemed appropriate by his/her physician.

I understand that my minor may need more invasive diagnostic or surgical procedures such as acne cyst injections, incision and drainage, cryo-therapy, and biopsies.

◯ I DO or ◯ DO NOT authorize and appoint the above-named person to accompany and give consent for and to undergo procedures.
My authorization is continuous ◯ YES or ◯ NO. If **NO,** please give specific date of visit ______/______/______
Payment is expected the day of the appointment and can be made by cash, check or credit card or payment can be made in advance over the phone.

______________________________________ _________/_________/_________
Signature of Parent/Legal Guardian Date

Phone: ______________________ Mobile: _____________________ Work: ________________________