DERMATOLOGY PARTNERS

of Western New York, LLP

PARENT/GUARDIAN AUTHORIZATION TO TREAT MINOR CHILD

(any child under the age of 18 years)

_____ _____

Patient Name **Date of Birth**

It is the policy of Dermatology Partners of Western NY to have a parent or legal guardian present during a minor patient's initial visit. This helps the parent/legal guardian to have a comprehensive understanding of your child's care and treatment options.

In the event a parent or guardian may not be present during a future visit(s), please read and sign the below agreement.

____I, the undersigned parent/legal guardian, of the minor child above do authorize the providers at Dermatology Partners of WNY to provide healthcare services to this minor in the absence of a parent/legal guardian. I understand that the healthcare services may include, but are not limited to examination, medical diagnosis and treatment.

____I, the undersigned parent/legal guardian, of the minor child above do authorize the following person(s) to attend future visits with this minor for treatment with the providers at Dermatology Partners of WNY. I understand that the healthcare services may include, but are not limited to examination, medical diagnosis and treatment.

Name_____ Relationship_____

Name_____ Relationship_____

Please note that should your child require an invasive procedure, such as a surgical excision, biopsy, or laser treatments, a parent/legal guardian must be present at that appointment.

This authorization shall remain in effect until_____

(If left blank, indefinitely or until minor is of legal age)

_____

Signature of Parent/Legal Guardian Date

_____

Printed name of Parent/Legal Guardian Relationship

12/29/17