PERMISSION TO ACCOMPANY A MINOR

I, ______________________________, give permission to ______________________________
(Name of Parent/Guardian) (Name and relationship of adult accompanying child)

to accompany my child _____________________________ and authorize treatment for my
(child's name and DOB)
child in accordance with the office policy of Skin P.C. This includes bringing the child into the office of Skin P.C., providing a history of present illness, disclosing protected health information, and witnessing any physical exam completed by the provider. This adult has the responsibility to relay any diagnosis, treatment plan or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone if needed and to be financially responsible for all copays, deductibles and coinsurance.

This authorization is effective from: _______________ to _______________.
(effective date) (end date)

Parent/Legal Guardian Signature: ____________________________ **Date**: __________

Adult Chaperone Signature: ____________________________ **Date**: __________

PERMISSION TO TREAT A MINOR
(Child Age 16 – 18 Years ONLY)

I ________________________ give permission to my child _________________________
(Name of Parent/Guardian) (Name of child age 16-18 years)
to attend his/her dermatology appointment alone without my presence and authorize treatment for my child in accordance with the office policy of Skin P.C. This includes providing a history of present illness, disclosure of protected health information, 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 if needed and to be financially responsible for all copays, deductibles and coinsurance.
This authorization is effective from: ______________ to ______________.
(effective date) (end date)

Parent/Legal Guardian Signature: ____________________________ **Date**: __________

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