PARENT/GUARDIAN AUTHORIZATION TO TREAT MINOR CHILD
(any child under the age of 18 years old)

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

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

_____ _____
Patient Name Date of Birth

____I, the undersigned parent/legal guardian, of the minor above do authorize the providers at Dermatology Associates of Rochester 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 above do authorize the following person(s) to attend future visits with this minor for treatment with the providers at Dermatology Associates of Rochester. 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

nb-5/18/16