DERMATOLOGY ASSOCIATES OF ROCHESTER
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Parent/Guardian Authorization to Treat a Minor Child (<18 years old)

It is the policy of Dermatology Associates of Rochester that a parent or legal guardian **must** be present during a minor patient's initial visit. This helps the parent/legal guardian to have a comprehensive understanding of the minor patient'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. We reserve the right to require a parent or legal guardian to be in attendance, at our discretion:

Patient name: _____ Patient date of birth: _____

I, the undersigned parent/legal guardian of the above-named minor patient, do authorize the providers at Dermatology Associates of Rochester to provide healthcare services to this minor patient 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 above-named minor patient, do authorize the following person(s) to attend future visits with this minor patient 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.

1. _____ - _____
   Name Relationship
2. _____ - _____
   Name Relationship

Please note that should a minor patient require an invasive procedure, such as a surgical excision, biopsy or laser treatments, or any other medically significant procedure as determined by the minor patient's treatment team, 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.

_____
Parent/Guardian Name (Printed)

_____ _____
Parent/Guardian Signature Date