CENTRAL MINNESOTA DERMATOLOGY

Consent for Treatment of Minor

This authorization is to be used if the parent or legal guardian is unable to attend an appointment related to a minor child. Central Minnesota Dermatology reserves the right to require a parent or legal guardian be present for certain types of treatments or procedures.

Please Print Clearly

Patient's Name: _____ DOB: _____

I, as parent or legal guardian of the above minor child, do hereby authorize the person or persons listed below to be able to consent to any examination, treatment, medical diagnosis, and to be able to receive and discuss medical care in my absence. I understand that treatment and care options may be part of the visit and acknowledge that I am releasing these decisions to be made on my behalf. I release, indemnify, and hold harmless any providers or staff at Central Minnesota Dermatology who act in conjunction with this release.

I give authorization for the following person or persons to consent to treatment and services for my minor child.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

**I acknowledge that this authorization will stay in effect until the minor child reaches the age of 18 or until I revoke this authorization in writing.

Printed Name of Parent / Legal Guardian: _____

Signature: _____ Date: _____

I permit a copy of this authorization to be valid in place of the original.

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<u>To cancel this authorization – please complete the section below.</u>

To revoke this authorization removes all person or persons listed.

I hereby revoke the above authorization / authorizations for treatment and understand that a minor child must be accompanied to any future appointments.

Printed Name of Parent / Legal Guardian: _____

Signature: _____ Date: _____

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