NORTHSHORE DERMATOLOGY CENTER, S.C.

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CONSENT TO TREATMENT OF A MINOR

This policy is effective in cases where a patient who is a minor (a person under the age of 18) is seeing for treatment but is not accompanied to an appointment by a parent or legal guardian. In such cases the minor patient, must present a signed authorization with the information listed below to obtain treatment; the minor must have been seen initially with a parent or legal guardian to consent in person to ongoing treatment.

● The name of the Provider treating the minor
● Minor's Full Name
● Minor's Date of Birth
● The procedure that the parent is consenting to for the minor child
● The printed name and signature of the parent or guardian
● Effective Date/s for Consent

I am the parent or legal guardian of ______________________________(Minor's Name), and I authorize, ________________________(Provider's Name), To treat ____, Date of Birth _________________for ____(Minor's Procedure). This authorization is effective from: _______________________ to: _________________________.

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Parent/Guardian Name (Printed)

________________________________ ___________________________
Parent/Guardian Signature Date

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