AUTHORIZATION & CONSENT FORM FOR A MINOR

PATIENT NAME: _____ DATE OF BIRTH:_____

I, the parent/legal guardian, authorize the health care professionals of Contour Dermatolgoy & Cosmetic Surgery Center to provide medical care to my son/daughter; including, but not limited to, diagnostic examination (including radiological and laboratory testing), and necessary medical treatment (including minor surgical procedures).

By signing this form, I am agreeing to the following below:

_____
INITIALS

All minors seeking medical treatment must be accompanied by a parent/legal guardian during the first initial visit. This helps the parent/legal guardian have a comprehensive understanding of your child's care and treatment options. After the initial appointment, a minor may be seen for treatment without a parent/guardian present if child has a written authorization from the parent/guardian.

_____
INITIALS

Please note that at the providers request that should your child be recommended an invasive procedure, such as a surgical excision, biopsy or laser treatments, a parent/legal guardian must be present at that appointment or give same day verbal consent.

_____
INITIALS

I, the parent/legal guardian understand that this consent will be valid indefinitely unless revoked by the parent/legal guardian in writing. I, the parent/legal guardian further understand that, once the minor patient reaches 18 years of age, my consent for treatment is no longer required.

Please provide the medication (prescription or non-prescription) the above named minor is currently taking?

Please describe any medical condition(s) the medical provider should be aware of before treatment?

This authority shall begin on date signed below:

SIGNATURE: DATE:

PRINT PARENT/ LEGAL GUARDIAN NAME:

PRIMARY PHONE NUMBER: RELATIONSHIP TO MINOR:

SECONDARY PHONE NUMBER: