Name:
Age: DOB:
DOS:
MRN:

DERMATOLOGY SPECIALISTS

MINOR CONSENT FOR MEDICAL CARE

Law requires that patients under 18 years of age that we obtain consent from the parent or legal guardian PRIOR to any medical treatment, except for treatment for which a minor may provide valid consent under Minnesota law (pregnancy and associated conditions, venereal disease, and alcohol and other drug abuse). A parent or legal guardian (or proxy decision-maker, as authorized below) must be present for any patient who is under 18 years of age.

Patient Name: _____ **Birth Date**: _____
First M.I. Last

Parent/Legal Guardian : _____ Date of Birth: _____ Relationship: _____
First M.I. Last

Address: _____
City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Please fill out the below information if a parent or legal guardian will not be present for any patient that is under 18 years of age.

Authorization for other individual to accompany minor patient under 18 years of age and consent to routine medical care.	I authorize _____ (Name of person being authorized) Relationship to Patient _____ (Name of person being authorized) Relationship to Patient _____ (Name of person being authorized) Relationship to Patient to consent to and authorize Dermatology Specialists to provide medical care for my minor child identified above and to receive medical information pertinent to the care and treatment of this minor child. Medical care may include but is not limited to medical evaluation, physical examination, lab work, prescribing medications, procedures and follow-up care for treatment consented to by the legal guardian. I understand that I am still financially responsible for all medical expenses incurred by my child during these appointments. Authorization valid until revoked in writing by the parent/legal guardian, unless an alternative expiration date is provided here: _____ / _____ / _____ . Month Day Year
Authorization for minor patient to be unaccompanied for treatment	I authorize _____ to go independently to appointments. Minor Child Name Dermatology Specialists has my permission to provide medical care in my absence. Routine medical care may include but is not limited to medical evaluation, physical examination, lab work, prescribing medications, procedures and follow-up care for treatment. I understand that I am still financially responsible for all medical expenses incurred by my child during these appointments Authorization valid until revoked in writing by the parent/legal guardian, unless an alternative expiration date is provided here: _____ / _____ / _____ . Month Day Year

_____ _____
Parent or Legal Guardian Signature Date

_____ _____
Parent or Legal Guardian Printed Name Date

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