

REN

DERMATOLOGY

Authorization for Medical Treatment of a Minor

MINOR PATIENT INFORMATION

Patient's Full Name ("Minor Patient"): _____

Date of Birth: ____ / ____ / _____

AUTHORIZATION OF TREATMENT IF UNACCOMPANIED

- Parent/Guardian **DOES NOT AUTHORIZE** Minor Patient to be treated **WITHOUT** Parent/Guardian or Chaperone present.
- Parent/Guardian **AUTHORIZES** Minor Patient to be treated **WITHOUT** Parent/Guardian or Chaperone present.

AUTHORIZATION OF TREATMENT IF ACCOMPANIED BY CHAPERONE

- Parent/Guardian **DOES NOT** authorize a Chaperone for Minor Patient.
- Parent/Guardian **AUTHORIZES** Minor Patient to be treated without Parent/Guardian present if accompanied by one of the following Chaperones (**MUST BE OLDER THAN 18**):

Name: _____ Relationship to patient: _____ Phone: (____) ____ - _____

Name: _____ Relationship to patient: _____ Phone: (____) ____ - _____

Name: _____ Relationship to patient: _____ Phone: (____) ____ - _____

EMERGENCY CONTACT

Parent/Guardian **AUTHORIZES** Provider to contact one of the following persons if Parent/Guardian unavailable:

Choice 1: Name: _____ Relationship to patient: _____ Phone: (____) ____ - _____

Choice 2: Name: _____ Relationship to patient: _____ Phone: (____) ____ - _____

AUTHORIZATION FOR MEDICAL TREATMENT

I, Parent/Guardian of Minor Patient, hereby request, authorize, and consent for Ren Dermatology and its providers and staff to deliver routine medical care to Minor Patient as they may deem necessary or advisable for medical diagnosis or treatment. I have the legal right to preauthorize Ren Dermatology and its providers and staff to deliver routine medical treatment and services to Minor Patient. Routine medical care and interventions may include, but are not limited to, medical evaluation, physical examination, in-office testing, and minor procedures (for example, without limitation, destruction/treatment of skin lesions with liquid nitrogen or medication, skin biopsies, intralesional injections, intense pulsed light). My signature means that I have read this form or have had it read to me and explained in the language that I can understand.

Print Name (Parent/Guardian): _____ **Relationship to Minor:** _____

Signature (Parent/Guardian): _____ **Today's Date:** _____

This Authorization will remain in effect for 12 months OR until terminated by Parent/Legal Guardian OR until Minor Patient's eighteenth birthday.