EVOLVE
DERMATOLOGY

Authorization to Treat Minor Patient in Absence of Parent/Guardian

I, _____, the parent and legal guardian of _____, herby
(name of parent/guardian) (name of child)

authorize _____ to accompany my above-named child to office visits
(name of adult accompanying child to office)

with _____ and to consent to the examination and/or treatment of
(name of physician/physicians/practice)

of my child during the office visits.

This authorization:

- ☐ Is effective only on _____(month/day/year).
- ☐ Is effective from _____ to _____ month/day/year.
- ☐ Is effective until revoked by me in writing.

I reserve the right to revoke this authorization at any time by writing to the above named physician/practice. I understand that my child (under 18 years of age) cannot attend his/her appointment without the accompaniment from the adult listed above.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date