DARTMOUTH
DERMATOLOGY
ASSOCIATES

368 Faunce Corner Road / North Dartmouth, MA 02747
Tel: 508-998-1994 / Fax: 508-998-5781

# Authorization to treat a Minor

**PATIENT INFORMATION:**

Patient Name:______________________________

Date of Birth:______________________________

Home Address:______________________________

City:______________________________

State:______________________________

Date of Appointment:______________________________

**PARENT/GUARDIAN COMPLETE THE FOLLOWING**:

I, the undersigned parent/legal guardian, of the minor named above, do authorize the physicians, physican assistants and/or nurse practitioners of Dartmouth Dermatology to provide healthcare services to this minor in the absence of a parent or legal guardian. I understand that the healthcare services may include, but are not limited to: examination, medical or surgical diagnosis, local anesthetic, and preventative and/or curative treatment.

State any restrictions or exceptions:______________________________
______________________________
______________________________

Parent/Guardian Name (please print or type):______________________________

Parent/Guardian Signature:______________________________

Telephone number where you can be reached at the time of minor's appointment:______________________________

Home Phone:______________________________

Cell Phone:______________________________

Work Phone:______________________________

Please fax ***completed*** form to: 508.998.5781 or mail to the above address, or have your child bring the form with him/her to their appointment.