AUTHORIZATION TO PROVIDE MEDICAL SERVICES

The medical staff at Dermatology Associates has my permission to provide medical care services to my minor child without my physical attendance at the time of service. I authorized the person(s) listed below to accompany my child in my absence.

Patient name: ___________________________________ Date of Birth: ______________

Caregiver name: ____

Parental signature: _______________________________ Date: ____________________

Please list any instructions below:

This consent will be in effect until revoked in writing by the parent giving such authorization.