Seraly Dermatology

Parental Authorization to Treat Minor Child When Not Accompanied by Parent or Guardian

I recognize that Mark P. Seraly, MD, PC & Associates requires permission from a child's parent or guardian before providing medical service when the child is accompanied by someone other than the parent or legal guardian or presents by him or herself. When parents/legal guardians are not immediately available and advanced consent has not been provided, time must be taken to obtain permission and treatment may be delayed or even denied. However, please note that during an emergency, care would not be delayed.

I also acknowledge that a specific treatment such as administration or medication or procedure during a visit will require my verbal consent.

Below, please note my parental authorization given so that my minor child may receive treatment at Mark P. Seraly, MD, PC & Associates without his or her parent being present. This authorization will become part of the patient record.

Patient's Name		**Date of Birth**	
Address			

Part A

_____(Initial) This certifies that the person listed below has my permission to authorize necessary medical care for my child. This authorization is in effect until revoked by me in writing.

The following person(s) have my permission to authorize medical care for my child and to sign any necessary general consents or acknowledgements on my behalf. The following person will **present valid ID** for identification purposes and sign forms signifying my parental responsibility for payment.

Name	
Address	
Name	
Address	

AND/OR

Part B

_____(Initial) My minor child, who is at least 16 years of age and named above, may present unaccompanied by an adult and receive treatment per this authorization. My child has permission to authorize my parental responsibility for payment if able to provide valid acceptable identification.

Parent/Legal Guardian Name		**Signature**		**Date**	
Witness Name		**Signature**		**Date**	

Staff Only: Date Received: _____