Atlanta West DERMATOLOGY
MEDICAL SURGICAL PEDIATRIC

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Consent to treat minor patient without parent/legal guardian present

Minor's name: _____ DOB: _____

For those occasions when you may not be with your child, please list those individuals who may give us consent to see your child.

Name: _____ Relationship to patient: _____

Name: _____ Relationship to patient: _____

Authorization:

I _____ (*parent/legal guardian name - please print*) request and authorize Atlanta West Dermatology & Surgery Center, P.C. and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child accompanied by the above mentioned designated adult. I am also aware that the adult presenting the child is responsible for payment of the patient portion at the time of service.

I have the legal right to preauthorize Atlanta West Dermatology & Surgery Center, P.C. and its personnel to deliver routine medical treatment and services to my child. Routine medical care and interventions may include, but are not limited to: medical evaluation, physical exam and prescription medication therapies. Verbal consent may still be needed for injections, blood draws, liquid nitrogen treatment, skin biopsy, and excisions.

I have read, understand, and give my consent as stipulated above. My signature means that I have read this form and/or have had it read to me and explained in a language that I can understand.

Parent/Legal Guardian name: _____ *(please print)*

Parent/Legal Guardian signature: _____ Date:_____

I *(parent/legal guardian name*) _____ wish to give consent for the above named minor to receive medical care **without an accompanying adult**. This consent may only apply to **minors age 16 and older**.

Parent/Legal Guardian signature: _____ Date: _____