

# **NORTHSHORE DERMATOLOGY CENTER, S.C.**

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## **CONSENT TO TREATMENT OF A MINOR**

This policy is effective in cases where a patient who is a minor (a person under the age of 18) is seeing for treatment but is not accompanied to an appointment by a parent or legal guardian. In such cases the minor patient, must present a signed authorization with the information listed below to obtain treatment; the minor must have been seen initially with a parent or legal guardian to consent in person to ongoing treatment.

- The name of the Provider treating the minor
- Minor's Full Name
- Minor's Date of Birth
- The procedure that the parent is consenting to for the minor child
- The printed name and signature of the parent or guardian
- Effective Date/s for Consent

I am the parent or legal guardian of \_\_\_\_\_ (Minor's Name), and I authorize,  
\_\_\_\_\_ (Provider's Name), To treat \_\_\_\_\_,

Date of Birth \_\_\_\_\_ for \_\_\_\_\_ (Minor's Procedure).

This authorization is effective from: \_\_\_\_\_ to: \_\_\_\_\_.

\_\_\_\_\_  
Parent/Guardian Name (Printed)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

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