Rocky Mountain
DERMATOLOGY

Authorization to Treat a Minor

This consent will remain effective until _____. This period is defined as one day, one week, one month or one year. **This form cannot exceed 1 year.**

I (We) the undersigned parent(s) or legal guardian of _____, a minor, do hereby authorize and consent to treatment rendered by the physicians, physician assistant and medical staff at Rocky Mountain Dermatology. It is understood that this authorization is granted to provide authority and power to render care in the exercise of the provider's best judgment. **A minor, by law, must be accompanied by a parent/guardian on the first scheduled appointment.**

Please remember that co-payments must be paid at the time of service and you are responsible for any remaining balance.

Patient Date of Birth: _____

Health Problems: _____

List any Restrictions: _____

_____

Telephone numbers where parents/guardian can be reached

Mother: _____

Home: _____ Work: _____ Cell: _____

Father: _____

Home: _____ Work: _____ Cell: _____

Legal Guardian: _____

Home: _____ Work: _____ Cell: _____

_____ _____

Siganture of Parent/ Legal Guardian Date

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