MOUNTAIN DERMATOLOGY
SPECIALISTS
diagnose | treat | heal

Authorization to Treat a Minor

This consent will remain effective until _____. **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 Mountain Dermatology Specialists. 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.

List any Restrictions: _____
_____
Patient Date of Birth: _____
Health Problems: _____

Telephone numbers where parents/guardian can be reached

Mother: _____ Home: _____ Work:_____
Cell:_____

Father: _____ Home: _____ Work:_____
Cell:_____

Legal Guardian: _____ Home: _____
Work:_____ Cell:_____

_____ _____
Signature of Parent/ Legal Guardian Date

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