

MOELLER

DERMATOLOGY

Consent to Allow Treatment of a Minor by Person Other Than Parent/Guardian

The undersigned parent(s) or guardian(s) of the minor patient authorizes the listed person(s) to consent to treatment of the minor patient including, but not limited to: emergency, anesthetic, prescription, pathology, laboratory or surgical services, when I am not available in person. It is understood that this consent is given in advance of any specific diagnosis or treatment being required, and gives authority to the provider of care to diagnose and treat the minor in the parent/guardian's absence.

Person(s) allowed to consent to treatment of patient (other than parent/guardian):

Name

Name

Name

Name

Current Medical Concerns of Patient: _____

Patient's Known Allergies: _____

Parent/Guardian Name:

Father: _____

Mother: _____

Business Phone: _____

Business Phone: _____

Home Phone: _____

Home Phone: _____

Address: _____

Address: _____

Patient Name

Parent/Guardian Name (please print)

Parent/Guardian Signature

Date

Note: This consent shall remain effective for either 1 year or until written revocation, signed by the minor's parent/guardian, has been received by this office.