Consent for Treatment of Minors

Patient Name: ____ DOB: __________________

This will verify that you have authorized providers from Gwinnett Dermatology to evaluate, diagnose, and treat your child for his or her dermatologic condition(s). This treatment will include, but not limited to, medications, procedures, biopsies, and labs needed to properly treat your child when they arrive at the office.

Unaccompanied Minors

______*(Initials)* *I grant permission to treat and provide any healthcare services to my child that the provider deems necessary for treatment, if my child arrives at the office unaccompanied.*

Minor Accompanied by Others

______*(Initials)* *If I am unable to accompany my child to the appointment, the below listed individuals have my permission to accompany my child. I authorize the listed individual(s) to view and discuss my child's Protected Health Information (PHI).*

__________________________________ __________________________
Name Relationship

__________________________________ __________________________
Name Relationship

You are acknowledging by your signature that the risks, benefits, and alternatives to the treatment(s) or examinations have been explained to you and/or your child (including the alternative of no treatment or examination); that you or your child have had the opportunity to ask questions; that any questions have been or will be answered; and that you agree to pay for these examinations and/or treatments.

Should the provider deem it appropriate or necessary, they will attempt to contact you directly for discussion of any unusual or different findings, or if there appears to be a need to initiate or change a treatment plan considered to warrant your immediate input or approval. For any questions or concerns on our part, you may be reached at: ______________________.

Should you not be available to confer with the provider, you understand that treatment may need to be rescheduled at a separate visit for which there may be additional charges.

This permission is valid until the patient reaches the age of 18 or is revoked by written notice to Gwinnett Dermatology.

I have the legal right to preauthorize Gwinnett Dermatology to deliver medical treatment to my child.

____ _____________________________________
Parent/Guardian Name Parent/Guardian Signature

____________________________________ ____________________________________
Guardian Date Of Birth Date