RICHMOND DERMATOLOGY

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Consent Form to Treat a Minor

Caregiver other than Parent/Guardian

Patient Name: _____Date/Birth_____

I, _____
PLEASE PRINT FULL NAME OF PARENT OR LEGAL GUARDIAN

do hereby state that I have legal custody of the minor patient listed above. I grant my authorization and consent

for_____
PLEASE PRINT FULL NAME OF DESIGNATED ADULT

to make decisions regarding the necessary and/or routine treatment of my child including, but not limited to, examinations, injections, anesthetic, medical, surgical, laboratory diagnosis and/or treatment. I also consent to hospital care, if recommended, to be rendered under the general or specific supervision of any licensed doctor. I understand that only myself and the Designated Adult listed above will have the authority to authorize treatment.

I understand that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority to the above named Designated Adult to give consent to any and all such diagnosis, treatment, or hospital care which a licensed doctor recommends.

I understand that I remain financially responsible for any expense incurred by the minor patient.

This authorization will remain in effect unless so designated in writing that such consent for treatment of the minor patient is cancelled.

This authorization is effective beginning _____

_____
SIGNATURE OF PARENT OR LEGAL GUARDIAN **DATE**

VERIFIED DRIVERS LICENSE/ID OF GUARDIAN **EMPLOYEE INTIALS** **DATE**