SkinSpeaks
Advancements in Dermatology | Spa M.D.

Treatment to Unaccompanied Minors

We recognize there are times when you are unable to attend your child's appointment. For your convenience, this form has been prepared for your authorization to allow medical care for your child in your absence.

□ I hereby grant SkinSpeaks: Advancements in Dermatology permission to treat my child for their dermatology concerns; including but not limited to, medications, procedures and labs needed to properly treat my child when they arrive at the office unaccompanied**. I understand that I am financially responsible for all medical expenses incurred by my child during these appointments.**

Minor Patient Name: _____ _____
First MI Last D.O.B.

□ I hereby authorize the following individual(s) listed below to obtain medical care; including but not limited to, office visits, medications, procedures and labs needed to properly treat my child listed above. I also authorize the individual(s) listed below to view or discuss my child's, as listed above, Protected Health Information (PHI).

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

_____ _____
Signature of Parent or Legal Guardian Date

_____ _____
Printed Name Relationship

This authorization will expire one year from date signed; however, I may change or revoke it any time.