AUTHORIZATION FOR TREATMENT TO MINOR

MINOR'S FULL NAME

DATE OF BIRTH	PATIENT NUMBER

I/We, the undersigned parent(s)/legal guardian(s), of the minor person listed above do authorize the practitioners of Dermatology Consultants of South Florida, PA to provide health services to this minor in the absence of a parent or legal guardian. This health service may include, but is not limited to: examination, preventative and/or curative treatment, medical diagnosis, and any consultation deemed necessary at the physician's discretion. Services shall not include research or experimentation.

I/We understand that risks, benefits, and alternatives of treatment will be discussed with me/us via telephone at the time of visit. No treatment will be administered without this discussion.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required and is given to encourage the physician to exercise his or her best judgment as to the requirements of such diagnosis or medical treatment in my/our absence.

NOTE: Not used as permission for vaccines.

Parent(s)/Legal Guardian(s) Information

ADDRESS

PHONE NUMBER	ALTERNATE NUMBER

This consent shall remain in effect until revoked, in writing, by parent(s) or legal guardian(s), or until a child may legally consent for him or herself.

SIGNATURE - PARENT OR LEGAL GUARDIAN	DATE
SIGNATURE - PARENT OR LEGAL GUARDIAN	DATE
WITNESS	DATE

I declare under penalty of perjury under the laws of the State of Florida that the foregoing is true and correct.

SIGNATURE	DATE

County of _____)
) SS
State of _____)

Subscribed and sworn to before me on this _____ day of _____, 20_____.

NOTARY PUBLIC	NOTARY STAMP
COMM. NO.	
COMM. EXPIRES	