Authorization to Treat Minor Patients

Dear Parent or Guardian,

Aspen Mountain Dermatology strives to provide the highest quality of care to all of its patients. We realize there are times when parents are busy and not able to bring their minor children in for their appointments and choose to have a relative or other designated person bring them in.

In order for us to evaluate and treat a minor child without the parent or legal guardian, we will need to have a signed authorization to do so. All patients that are 18 years of age and younger who come without their parent or legal guardian, will need sign the Authorization to Treat Minor Patients.

Court appointed legal guardians and/or foster parents will need to provide court documents to prove guardianship. If we don't have the signed authorization, the parent will need to accompany the minor.

We appreciate you choosing Aspen Mountain Dermatology for you and your family's dermatological care. If you have questions, please feel free to call us at (541)706-3819.

Authorization To Treat Minor Patient

I, _____ , parent or legal guardian
(Legal Guardian's Name)

of _____ ,
(Patient Name) (Date of Birth)

authorize Aspen Mountain Dermatology to evaluate and treat my child for:

- _____ specify condition (new condition will require new authorization).
- Or any common skin conditions such as acne, warts, rash, eczema, or psoriasis (including blood tests).

This authorization is in effect for twelve months from the date of my signature. I understand that if the condition does not improve, I may be required to attend the appointments to personally discuss my child's condition with the provider. I also understand I will be required to sign a separate consent for biopsies, excisions and any other surgical procedure. If I am not available to give consent for additional treatments, my child may be rescheduled when I am available to give consent. I also give the following individuals permission to bring my child to their appointment:

1. _____
(Name) (Relationship)

2. _____
(Name) (Relationship)

- I decline to authorize treatment to minor child and will be present at all scheduled appointments.

_____ _____
Signature of Parent or Legal Guardian Date