CONSENT TO TREAT UNACCOMPANIED MINOR

AUTHORIZATION

I have the legal right to preauthorize Dermatology Physicians of CT, PC, to deliver medical treatment to my child. I request and authorize Dermatology Physicians of CT, PC and its personnel to deliver medical care to my child named below.

Name _____

Date of Birth _____ Gender _____

TIME FRAME

Please select on of the following options:

_____ This authorization if valid and remains in effect until I revoke it in writing.

_____ This authorization is valid from _____ until _____

_____ This authorization if valid for this date only: _____

I understand that I may revoke this consent at any time in writing.

CONTACT INFORMATION

If *emergent* medical care is needed, first try to contact me regarding the medical situation of my child at the following number(s). If you are unable for any reason to contact me, then you may rely on the designated decision maker's (physician, nurse) medical judgment.

Parent's Name _____

Home Phone _____ Cell Phone _____

Work Phone _____ Other _____

_____ _____

Signature of parent or legal guardian Witness/Verification __in person __via phone

Date_____ Date _____