DARTMOUTH DERMATOLOGY

Authorization to Treat a Minor

PATIENT INFORMATION:

Patient Name:_____

Date of Birth:_____

Home Address:_____

City:_____

State:_____

Date of Appointment:_____

PARENT/GUARDIAN COMPLETE THE FOLLOWING:

I, the undersigned parent/legal guardian, of the minor named above, do authorize the physicians, physician assistants and/or nurse practitioners of Dartmouth Dermatology to provide healthcare services to this minor in the absence of a parent or legal guardian. I understand that the healthcare services may include, but are not limited to: examination, medical or surgical diagnosis, local anesthetic, and preventative and/or curative treatment.

State any restrictions or exceptions:_____

_____

_____

Parent/Guardian Name (please print or type):_____

Parent/Guardian Signature:_____

Telephone number where you can be reached at the time of minor's appointment:_____

Home Phone:_____

Cell Phone:_____

Work Phone:_____

Please fax ***completed*** form to: 508.998.5781 or mail to the above address, or have your child bring the form with him/her to their appointment.