AUTHORIZATION TO TREAT MINOR

This consent will remain in effect for one (1) full year from signature date below unless sooner revoked, in writing, delivered to the said agent.

I / We the undersigned, parent(s) or legal guardian of _____ a minor, do hereby consent to any anesthetic, medical or surgical diagnosis and treatment procedures which are deemed advisable by, and suggested, recommended, prescribed or directed by the physicians and/or nurse practitioners of Dermatology Specialists of Greater Cincinnati, Inc.

Patient's Name: _____Account# _____

Home Phone: _____

Birthdate: _____

Allergies to drugs or food: _____

Special Medication or Pertinent Information: _____

Parent or Legal Guardian: _____

Address: _____

Employer: _____

Address: _____

PHONE NUMBERS WHERE PARENTS OR GUARDIAN MAY BE REACHED

Father: _____ Business: _____ Cell: _____ Email: _____

Mother: _____ Business: _____ Cell: _____ Email: _____

Legal Guardian: _____ Business: _____ Cell: _____
(If Different from above)

Family Physician: _____ Phone: _____

AUTHORIZATION (PLEASE SIGN): _____

NO, I DO NOT WISH TO SIGN THIS AUTHORIZATION ( )

DATE: _____ WITNESSED BY: _____