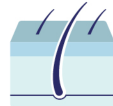

Medical Treatment Authorization for a Minor

Patient Name:____ Date of Birth:____________

This consent will authorize Skin Professionals West to provide medical care for the minor child listed above without my physical presence.

I understand that I may revoke this request at any time.
This consent will automatically expire 1 year from the signed date.

Name and signature of parent or guardian: ____

Relationship to above patient: ____

Date consent obtained (verbal or written): ____

Written Consent obtained by (requires the signature of one witness):

Name and signature of witness: ____

Date written consent obtained: ____

Verbal Consent obtained over the phone, must be given to two staff members of Skin Professionals West. The following two employees received verbal consent from guardian to treat the above minor.

1st Employee's name and signature: ____

2nd employee's name and signature: ____

Date verbal consent obtained: ____

Reason patient is unable to consent for themselves: Patient is under the age of 18 and is considered a minor.

This Medical Consent will expire on: ____
(1 year from the date listed above)