DARABI
DERMATOLOGY

Medical Treatment Authorization for a Minor

Patient Name: _____ Date of Birth: _____

This consent will authorize Darabi Dermatology 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 one year from the signed date.

Parent / Guardian Information:

Name of Parent/Guardian: _____ Relationship to Patient: _____

Signature of Parent/Guardian:_____ Date of Consent:_____

Written Consent Obtained By:

Name of Darabi Dermatology Staff Member Witness: _____

Signature of Darabi Dermatology Staff Member Witness: _____

Date Written Consent Obtained:_____

Verbal Consent Obtained Over the Phone:

Must be witnessed by two staff members of Darabi Dermatology. The following two employees received verbal consent from the parent or guardian to treat the above minor:

Name of 1st Darabi Dermatology Staff Member Witness:_____

Signature of 1st Darabi Dermatology Staff Member Witness: _____

Name of 2nd Darabi Dermatology Staff Member Witness: _____

Signature of 2nd Darabi Dermatology Staff Member Witness: _____

This Treatment of Minor's Consent Will Expire On: _____