ADVANCED DERMATOLOGY ASSOCIATES OF SUSSEX COUNTY, P.C.

Authorization to Treat a Minor

Patient Name: _____ **Date of Birth:** _____

Any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the patient arrives with someone other than a parent/legal guardian or an Authorized Person, treatment will be delayed until authorization is obtained from the parent or legal guardian.

Please list below the individuals that have permission to accompany your child to their appointments and consent to medical treatment on your behalf:

Name of Authorized Person	Relationship to Patient

Any person(s) listed above will be required to present photo ID. For convenience we may keep a photocopy of the ID.

This form does not grant authorization for above persons to obtain medical records and anything protected by HIPAA.

Limitations: Please list any specific limitations on the types of medical services for which this authorization is given. If none, please state none": _____

_____

_____

Contact information for parents/guardians in case of emergency:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

_____

Parent/Legal Guardian Name (please print)

_____ _____

Parent/Legal Guardian Signature Date

This form is valid for one (1) year from the above date