WEST MICHIGAN DERMATOLOGY
Jack A. Dekkinga, MD, PC

Jack A. Dekkinga, MD Gina C. Ang, MD J. Gabriel Vasquez, MD Douglas A. Winstanley, DO
Ronald W. Reusch, PA-C Molly R. Duiven, PA-C Amber E. Kintigh, PA-C Kurt J. VanDerVeen, PA-C Sarah L. Mcintyre, PA-C

CONSENT TO TREAT FORM – MINOR PATIENT

AUTHORIZATION TO TREAT A MINOR PATIENT WITHOUT PARENTAL PRESENCE

I am authorizing treatment for my minor child _____ DOB: _____

☐ I authorize my minor child to be seen in the office without an accompany adult. Parent Initials _____

☐ I authorize my minor child to be accompanied by the following person(s):

Name	Relationship	Phone #	Level of Access
			Emergency Contact: ☐ Yes ☐No Medical Information: ☐ Yes ☐No Financial Information: ☐ Yes ☐No Authorize Treatment: ☐ Yes ☐No
			Emergency Contact: ☐ Yes ☐No Medical Information: ☐ Yes ☐No Financial Information: ☐ Yes ☐No Authorize Treatment: ☐ Yes ☐No

The above listed individuals may authorize the following types of treatment without my explicit consent. Any procedures not listed on this form will not be performed without my verbal or otherwise specific written consent.

Please check those that apply

☐ **Office Visits**

☐ **Wart Treatments (chemical destruction and/or surgical removal)**

☐ **Injection of a cyst (acne or other similar type)**

☐ **Injection for a specified diagnosis such as a rash, eczema, allergic reaction, etc**

☐ **Biopsy of a suspicious spot – this would include additional pathology charges**

***Medical Information that may be shared may include: Office Notes, Lab Results, Pathology Reports, X-Rays, Hospital notes, Nursing Home, Home Health, Hospice, Records of other Physicians offices, Records of HIV and Communicable disease testing, and Record of mental health or substance abuse treatment UNLESS otherwise stated by the patient.*

Disclosure of information will be provided by: **West Michigan Dermatology**
4285 Parkway Place SW, Grandville MI 49418
3124 N Wellness Dr, Suite 50, Holland, MI 49424

- This authorization will expire at the end of the calendar year in which it was signed or at the time the patient turns 18 (whichever date comes first).
- The parent/guardian has the right to terminate this request at any time – this request must be made in writing and submitted to the practice Privacy manager
- The practice places no condition to sign this authorization on the delivery of healthcare or treatment
- We have no control over the person(s) you have listed to receive your Protected Health Information once disclosed we have no responsibility for what the authorized person does with the information.

Parent or Legal Guardian Signature: _____Date:_____

Patient Representative Signature: _____Date: _____

By signing this form, I represent that I am the legal representative of the above patient & will provide written proof (e.g. Power of Attorney, guardianship papers, etc.) that I'm legally authorized to act on this minor child's behalf with respect to this authorization form.

***All signatures valid for the duration of the calendar year in which they are signed*