



AUTHORIZATION TO TREAT A MINOR PATIENT WITHOUT PARENTAL PRESENCE

I _____ [printed name of parent / legal guardian] authorize my minor child: _____ DOB: _____

to be accompanied by the following person(s):

Name: _____
Relationship: _____
Phone #: _____

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Relationship: _____
Phone #: _____

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
(i.e.: rash, eczema, allergic reaction, etc.)
- Biopsy of a suspicious spot
(this would include additional pathology charges)

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The above listed individuals may authorize the indicated types of treatment without my explicit consent. Only procedures listed on this form will be performed. Any additional treatments or procedures will require my verbal or otherwise specific written consent.

**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’s parent or legal guardian.

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

*This authorization will expire at the end of the calendar year from when 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.

Disclosure of information will be provided by: **West Michigan Dermatology**

Parent or Legal Guardian Signature: _____ Date: _____

Patient Representative Signature: _____ Date: _____

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