CLARITY DERMATOLOGY
AND COSMETIC CENTER

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AUTHORIZATION AND CONSENT OF PARENT(S) OR LEGAL GUARDIAN(S)

I do hereby solemnly swear that I have legal custody of the aforementioned minor child.

In order for us to treat a minor without a parent/legal guardian present, please complete this form and return it with a copy of the parent/legal guardian's drivers license to Clarity Dermatology and Cosmetic Center.

I, _____ (print name here) am the parent/legal guardian

of_____ (print name of minor), currently a minor whose

date of birth is _____.

I authorize Clarity Dermatology and Cosmetic Center to provide medical care to my son/daughter, including but not limited to: diagnostic examination (including laboratory testing), treatment procedures, any necessary services and prescribing of medication as deemed appropriate by his/her physician.

I further understand that, once my child reaches the age of majority, my consent for treatments is no longer required.

This consent will remain in effect until the patient reaches the age of eighteen unless revoked in writing to Clarity Dermatology and Cosmetic Center.

By signing this, I acknowledge I have read and agreed to this consent and that any questions I had prior to signing were answered by Clarity Dermatology and Cosmetic Center.

I understand that office staff will not be able to convey the details of the appointments to me later in the day, rather, it is the responsibility of my child to relay any diagnosis, treatment plan, or prescription(s) back to me as the parent or legal guardian. The minor will also be responsible for providing a history of present illness and any needed protected health information. I understand that payment is expected the day of the appointment. I agree to be financially responsible for all charges, copays, and coinsurance incurred in these visits.

This authorization is effective commencing on:

DATE: _____

_____
Signature of Parent/Guardian

Phone Number:_____

Email: _____