Consent Form for Preauthorization to Treat Minors

For families who are ongoing patients of (facility): **Boyle Family Dermatology**

It may be more convenient to have prior authorization for medical care delivered directly to minors without a parent having to be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.

AUTHORIZATION

I (we) request and authorize (facility): **Boyle Family Dermatology** and its personnel to deliver medical care to my (our) child(ren) listed below:

PLEASE PRINT

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Name: _____ DOB: _____

Please try to contact me (us) regarding health care of my (our) child(ren) at the following phone number(s):

Parent's name: _____ Phone (office/home/Mobile): _____

Parent's name: _____ Phone (office/home/Mobile): _____

Other (relationship): _____ Phone (office/home/Mobile): _____

Date: _____ Signiture: _____

PRINT name and relationship:

_____

NOTE: If there are any special parental or custodial relationships (such as custody with one parent only, legal custody/guardianship with non-parent, etc.), please explain in the space below with your signature, printed name, and phone number at which you can be contacted.

_____

_____

_____

_____