COLORADO CENTER for DERMATOLOGY & SKIN SURGERY

AUTHORIZATION FOR TREATMENT OF MINOR

All minors are required to have a parent/legal guardian present with them for each appointment. By law, we are required to have a consent from a legal guardian to provide treatment to a minor. If a parent or guardian is unable to attend an appointment with the minor, then a signed authorization to treat a minor is required.

I request and authorize Colorado Center for Dermatology & Skin Surgery ("Colorado Dermatology") to deliver medical and/or cosmetic care to the minor listed below without my presence at the appointment. I further authorize Colorado Dermatology to bill any applicable charges to the provided medical insurance policy/policies.

Minor's Name: _____

Minor's DOB: _____

Authorization Time Period (please check <u>ONE</u> option below):

☐ Valid until revoked in writing by me or until minor is 18 years old (whichever is sooner)

☐ Only for Specific Appointment Date(s) or Treatment(s) (as specified below):

_____

Please list any comments or instructions for treatment of minor:

_____

_____

_____ _____

Signature of Parent/Guardian Date

_____ _____

Name of Parent/Guardian Relationship to Minor

_____ _____

Email for Parent/Guardian Phone Number for Parent/Guardian