Charlotte Dermatology
A tradition of care since 1939

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Consent to Treat a Minor

Date: _____

Patient Information

Name: _____ Date of Birth: _____

Address: _____

Responsible Party's Name: _____ Phone: _____

Emergency Contact: _____ Phone: _____

The undersigned hereby requests and authorizes Charlotte Dermatology, P.A. to perform diagnostic tests, procedures and render treatment to _____, a minor child.
Patient Name

This authorization extends to all Charlotte Dermatology offices, doctors, and office staff members.

As of the date below, the undersigned states and avows to have the legal right to select and authorize health care services for the minor child named above.

If applicable, under the terms and conditions of divorce, separation or other legal authorization, the consent of a spouse, former spouse, or other parent is not required. If authority to select and authorize the care should be revoked or modified in any way, the undersigned does hereby agree to notify Charlotte Dermatology, P.A as soon as possible.

_____ _____
Signature of Person Authorized to Sign for Patient Date

_____
Printed Name

_____ _____
Relationship to Patient of Person Authorized to Consent Witness