Parental Pre-Authorization for Medical Care to Minors

For families who are ongoing patients of Dermatology Associates, P.C. it may be more convenient to have prior authorization for medical care delivered to minors without a parent/guardian having to be present. Please review the following authorization for treatment (excluding surgery) and complete the information if you want to authorize such treatment in advance. This authorization is valid for one year from the date of the signature. IF applicable, be sure that we have a valid referral for each date of service. Your child cannot sign a referral waiver.

I (we) request and authorize Dermatology Associates, P.C. and its personnel to deliver medical care to my (our) child listed below:

Please Print:

Patient Name: _____ D.O.B._____

1) Parent/Guardian Name: _____

Phone (home/office/cellular): _____

Signature: _____ Date: _____

2) Parent/Guardian Name: _____

Phone (home/office/cellular): _____

Signature: _____ Date: _____