MacInnis Dermatology

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PRE-CONSENT FORM TO TREAT MINORS or PATIENT with/without GUARDIAN

Purpose: This form may be used to allow a child or an adult other than a parent to serve as a proxy decision maker for routine medical care and services.

AUTHORIZATION:

I hereby appoint: _____
Name Relationship

as a proxy decision maker to consent to and authorize routine health care treatment and services for my child listed below.

I, _____, the parent/guardian of:
Parent/Guardian Name

_____
Patient Name and Date of Birth

hereby empower and grant to ***MacInnis Dermatology*** permission evaluation and management for the above child aged 16-18 years of age/ward. I do hereby indemnify and hold harmless the physician and other persons who act in reliance upon this authorization. If the child arrives to the appointment unaccompanied, we will require verbal authorization for any treatment by the legal parent/guardian. If the child requires a more invasive procedure, such as surgery the parent/guardian must accompany the child to said appointment.

_____ _____
Print Name of Parent/Guardian Relationship to Patient

_____ _____
Signature Date

This consent expires upon the patient's 18th birthday.