Ada West
DERMATOLOGY

Minor Patient Name:	**DOB:**

Consent to Treat Unaccompanied Minor (Optional)

I, _____, as the parent and/or legal guardian of the
(Printed Name of Parent or Legal Guardian)
above listed patient, hereby grant Ada West Dermatology (AWD) and its medical personnel permission to treat the minor listed above in my absence.

- As the patient's parent and/or legal guardian I understand that I am required to accompany my minor child to their first visit. If I am not able to attend an appointment with my minor child, I will complete and sign all required consents prior to the appointment.

I authorize Ada West Dermatology to treat the minor for (choose 1):

- ☐ Any and all dermatologic conditions (preferred)
- ☐ Treatment of only the following condition(s): _____

  _____

  (please note that if you choose this option and the minor presents for, or asks about any additional issues, we will not be able to address those issues on that day and will have to reschedule a time when a parent or guardian can be present at the appointment).

- Treatment for all **new** medical concerns, not listed above, must be authorized in writing by a parent and/or legal guardian.

- This consent will expire on the patient's eighteenth birthday; or may be revoked in writing by the parent and/or legal guardian at any time (except to the extent that action has already been taken based on this consent.)

- To revoke this consent, please contact our Health Information Department. Ph: (208) 813-3248

Relationship (Please select one): ☐ Parent or ☐ Legal Guardian

Signature:_____ **Date:**_____

Name (Print):_____