NEW AGE DERMATOLOGY

AUTHORIZATION FOR TREATMENT OF A MINOR

Patient Name: _____

Date of Birth: _____

I, the undersigned parent/legal guardian, of the minor person listed above do authorize the physician and assistants of New Age Dermatology to provide health services to this minor in the absence of a parent or legal guardian. This health service may include, but is not limited to examination, preventative and/or curative treatment, x-ray, laboratory examination, anesthetic, medical or surgical diagnosis, and any consultation deemed necessary at the physician's discretion. Services shall not include research.

It is understood that this consent is given in advance of any specific diagnosis or treatment being required and is given to encourage and allow the physician to exercise her best judgment as to the requirements of such diagnosis or medical treatment in my absence.

This consent shall remain in effect until revoked, in writing, by parent or legal guardian or until child may legally consent for him or herself.

Signature of Parent or Legal
Guardian: _____

Date: _____

Witness: _____

Date: _____