ALLSKIN
DERMATOLOGY

Consent to Treat a Minor without a Parent/Guardian Present

In an effort to meet the rules and standards set forth by HIPAA and the California Medical Board we require a signed consent from the parents or legal guardian of any minor (anyone < 18 yrs old) who may receive treatments for a diagnosis that is non-life threatening. This consent form is your way of authorizing AllSkin Dermatology and its medical providers to evaluate your child in the case you cannot accompany them to their visit. Additionally, this form gives AllSkin Dermatology permission to perform specific reoccurring medical treatments that might be the outcome of a diagnosis made in our office (ex. reoccurring wart freezing, skin checks or acne treatment).

This form will be scanned and maintained along with your child's medical record on file and will be the basis for any action taken.

Patient Name: _____

Patient DOB:_____

I _____ (parent or guardian) grant AllSkin Dermatology the ability to perform medical services on my minor child in my absence.

I have read and understand the above information. My questions have been answered by AllSkin Dermatology to my complete satisfaction.

_____ _____

Patient's Parent/Guardian (Please print) Signature

Date:_____

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