



## **AUTHORIZATION TO PROVIDE MEDICAL SERVICES**

The medical staff at Dermatology Associates has my permission to provide medical care services to my minor child without my physical attendance at the time of service. I authorized the person(s) listed below to accompany my child in my absence.

Patient name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Caregiver name: \_\_\_\_\_

Parental signature: \_\_\_\_\_ Date: \_\_\_\_\_

Please list any instructions below:

***This consent will be in effect until revoked in writing by the parent giving such authorization.***