NORTHPOINT
DERMATOLOGY & MOHS SURGERY

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Fax: (516) 846-3305
www.NorthPointDerm.com

Authorization for Treatment of a Minor

Please complete this form if patient is under the age of 18 and unaccompanied by a parent or legal guardian.

Patient Name: _____
FIRST MIDDLE LAST

Date of Birth: _____/_____/_____ **Telephone**:_____
MONTH DAY YEAR

Address:_____

Emergency Contact: _____ **Relationship:**_____

Emergency Contact Telephone:_____

TO PARENT OR LEGAL GUARDIAN:
If your son, daughter, or ward will be under the age of 18 at the time of his/her visit, you have the option to consent, by signing this form, for your child to receive medical evaluation and treatment without you being present.

AUTHORIZATION FOR TREATMENT OF A MINOR

I, _____, being the parent or legal guardian of
FULL NAME OF PARENT/GUARDIAN

_____, give my consent to North Point
FULL NAME OF PATIENT

Dermatology & Mohs Surgery, the physicians, and medical staff, to administer such care, procedures and treatment that is deemed necessary and in the best interest of the patient. As long as the medical treatment is considered appropriate in the situation, in accordance with the generally accepted standards of medical practice for the particular type of condition or illness involved, I impose no specific limitations or prohibitions regarding treatment. I understand that this authorization is valid until the time in which the minor mentioned above reaches his/her 18th birthday.

Signature: _____ **Date**:_____

Address: _____ **City:** _____ **State:** ____ **Zip Code:**_____