ROCKY MOUNTAIN Dermatology
MEDICAL · SURGICAL · COSMETIC

AUTHORIZATION TO TREAT IN ABSENCE OF PARENT OR GUARDIAN

Patient's Name:_____ **Age:**_____ **Date of Birth:** _____

I hereby consent for my child to receive treatment while accompanied by the following individual(s) in my absence. I understand that I am responsible for following up on my child's treatment and ensuring their compliance with recommendations given by their provider. I agree to be financially responsible for the cost of my child's care.

Name:_____ Relationship to Patient:_____ Phone: _____

Name:_____ Relationship to Patient:_____ Phone: _____

I UNDERSTAND THAT BY NOT SIGNING THIS FORM MY CHILD MAY NOT BE SEEN BY ANY PROVIDER AT ROCKY MOUNTAIN DERMATOLOGY WITHOUT MYSELF OR ANOTHER LEGAL GUARDIAN PRESENT.

Legal Guardian Signature: _____

Legal Guardian Printed Name: _____ Date: _____

I hereby consent for my child to receive treatment **without** an authorized adult present. **Patients must be at least 16 years of age to be seen by themselves**. I understand that I am responsible for following up on my child's treatment and ensuring their compliance with recommendations given by their provider. I agree to be financially responsible for the cost of my child's care.

I UNDERSTAND THAT BY NOT SIGNING THIS FORM MY CHILD MAY NOT BE SEEN BY ANY PROVIDER AT ROCKY MOUNTAIN DERMATOLOGY WITHOUT MYSELF, ANOTHER LEGAL GUARDIAN, OR ANOTHER AUTHORIZED ADULT PRESENT.

Legal Guardian Signature: _____

Legal Guardian Printed Name: _____ Date: _____