Western New York Dermatology

297 Spindrift Drive
Williamsville, NY 14221

Consent to Authorize Routine Medical Care of a Minor Patient

At times, it may be beneficial for parents or guardians of minor children to authorize routine medical care in advance, particular if a parent or legal guardian cannot be present at the time of treatment. Please complete the following authorization for treatment if you wish to authorize such treatment for your child.

AUTHORIZATION
I hereby state that I am the parent of the child named below. I certify that there are no court orders that would prohibit me from authorizing Western New York Dermatology or Mohs Surgery at Western New York Dermatology and its staff to deliver routine health care to the child listed below.

CHILD'S Name ______________________ **DATE OF BIRTH** ______________________

What types of medical services do you wish to authorize?
(check all that apply)

- ☐ Well child care and treatment
- ☐ Immunizations
- ☐ Care and treatment of sick child
- ☐ Appropriate testing as required

This authorization expires on (not more than three months from today unless revoked sooner)

CONTACT INFORMATION
If the nature of the medical care is other than what has been authorized above, I wish to be contacted at the following telephone numbers:

Parent's Name ______________________ **Daytime Phone** ______________________
Evening Phone ______________________ **Cell Phone** ______________________

Parent's Name ______________________ **Daytime Phone** ______________________
Evening Phone ______________________ **Cell Phone** ______________________

____
Parent/ Legal Guardian Signature

____
Date

____
Print Name

HEALTHY COMPLEXIONS SPA
by Western New York Dermatology

Mohs Surgery