HARTSOUGH DERMATOLOGY

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Authorization To Treat Minors And Authorization For Continuing Care

I _____, being the parent/guardian of
(Parent/Guardian – please print)

_____, a minor
(Patient – please print)

hereby give permission to Hartsough Dermatology, to treat the above named minor.

I further authorize Hartsough Dermatology to treat the above named minor for medical care on subsequent appointments for the treatment of _____ until the course of treatment is concluded.

In the event of an emergency call _____
(Please print name)

_____
(Please print relationship)

_____
(Telephone number)

Signature: _____ Date: _____
(Parent/Guardian)

Please state relationship: _____