COLORADO DERMATOLOGY SPECIALISTS

PERMISSION TO TREAT A MINOR

I _____ give permission to my child_____
(name of guardian/parent) (name of child under the age of 18)
to attend his/her appointment alone without my presence and authorize treatment for my child in accordance with the office policy of CO. DERMATOLOGY SPECIALISTS. This includes providing a history of present illness/condition, disclosure of protected health information, and responsibility for relaying any diagnosis, treatment, or prescription(s) to the parent or legal guardian listed above. I agree to be available by phone and to be financially responsible for all co-pays and coinsurance. This authorization is effective on:
_____ and expires _____.
(Today's date) (Date authorization is not valid)

_____
(Signature of Parent/Legal Guardian)

Child's Name_____ Child's DOB_____

Parent's Home #_____
Parent's Cell #_____
Parent's Work#_____

Where can you be contacted in case of emergency? _____
Comments: _____

Health Insurance Information
***If no change, skip to next section**
New Insurance information listed below:
Insurance Company_____ Policy Holder _____
ID Number_____ Group Number _____
Effective Date_____ Co-pay _____

Child's Health Information
Currently prescribed or over-the-counter medications and doses:

Allergies, illnesses or other information?