RICHMOND DERMATOLOGY

9816 Mayland Drive Richmond, VA 23233

Consent to Treat a Minor

Caregiver other than Parent/Legal Guardian

Patient Name _____ **Date of Birth** _____

I, _____

PLEASE PRINT FULL NAME OF PARENT OR LEGAL GUARDIAN

Do hereby state that I have legal custody of the minor patient listed above. This authorization is given to provide authority to the below names, to give consent to any and all such diagnosis, treatment, or hospital care which a licensed doctor/practitioner recommends.

☐ **I authorize the patient to act as my agent to consent**

☐ **I authorize the designated adult(s) below to act as my agent to consent**
PLEASE LIST THE NAME(S) OF THE DESIGNATED ADULT(S) BELOW

☐ **Not applicable**

I understand that only myself and the designated adult(s) listed below will have the authority to authorize treatment. I understand that I remain financially responsible for any expense incurred by the minor patient.
This authorization will remain in effect unless so designated in writing that such consent for the treatment of the minor patient is cancelled.

This authorization is effective beginning on _____

Please list the adult(s) designated to authorize care

NAME	RELATIONSHIP	DOB	PHONE NUMBER

_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN ***DATE***