READING DERMATOLOGY
MEDICAL, COSMETIC & SKIN CANCER CENTER

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Authorization to Treat Minor Patient in Absence of Parent/Guardian

I, _____ (name of parent/guardian), the parent and legal guardian of _____ (name of child), hereby authorize _____, (name of adult accompanying child to office) to accompany my above-named child to office visits with _____ (name of physician/physicians) and to consent to the examination and/or treatment of my child during the office visits.

This authorization:

- ☐ Is effective only on _____(month/day/year)
- ☐ Is effective from _____ to _____ month/day/year.
- ☐ Is effective until revoked by me in writing

I reserve the right to revoke this authorization at any time by writing to the above named physician. I understand that my child (under 18 years of age) cannot attend his/her appointment without the accompaniment of the adult listed above.

_____ _____
Signature of Parent/Guardian Date

_____ _____
Signature of Witness Date