PENINSULA
Dermatology
SKIN CANCER SURGERY CENTER

MINOR MEDICAL CONSENT AUTHORIZATION

I, _____, am the parent of the child listed below.
Parent's Name

There are **NO** court orders in effect that would keep me from having the power to give another person permission to bring in and consent to care for my child.

I, _____, am the legal guardian or legal custodian of the child.
Name of Legal Guardian or Legal Custodian

BY COURT ORDER (copy attached) and where there are no court orders in effect that would keep me from having the power to give another person permission to bring in and consent to care for my child.

PATIENT NAME: _____ DOB: _____

Adults that are granted permission to consent to medical examinations and treatments and granted permission to receive health information about my child:

NAME: _____ RELATIONSHIP: _____
_____ RELATIONSHIP: _____
_____ RELATIONSHIP: _____
_____ RELATIONSHIP: _____

Those persons named above may have access to any and all records, including, but not limited to, insurance records regarding any such services.

I confer the power of consent freely and knowingly in order to provide for the child and not as the result of pressure, threats or payments by any person or agency. This document shall remain in effect until it is revoked by my written notification to my child's medical provider and the person(s) named above.

In witness of, I have signed my name to this medical consent authorization, on this _____ day of _____20__ in _____, VA.

_____ _____
Printed Name of Parent/Guardian Signature

_____ _____
Witness Printed Name Signature

General Dermatology • Mohs Micrographic Surgery

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