Parental Authorization to Treat a Minor Child (Patient Under 18) When Not Accompanied by Parent or Legal Guardian

Boise Dermatology, 3109 S. Meridian Road, Meridian, ID 83642, (208) 888-0660

I ____, as the parent/legal guardian, hereby grant Boise Dermatology and its medical personnel permission to treat the minor listed below without a parent being present. This authorization will become part of the patient record.

____	______________________________
Print Full Name of Minor Child	Patient Date of Birth

______ **(Initial)** I understand that as the patient's parent or legal guardian, **I must accompany them at their first visit,** as well as to any visit that the minor presents with a new problem. If I am un able to accompany the minor for treatment of an established problem, I must designate another adult below.

______ **(Initial)** I acknowledge that a specific treatment such as administration of a medication or procedure during a visit will require my verbal consent.

______ **(Initial)** My minor child, named above, who is at least 16 years of age and/or has a valid driver's license, may present unaccompanied by an adult and receive treatment per this authorization. My child has permission to authorize my parental responsibility for payment.

____	______________________________
Print Full Name of Designated Adult	Relationship
____	______________________________
Address	Phone Number

______ **(Initial)** The person(s), listed above, has my permission to authorize medical care for my child and to sign any necessary general consents or acknowledgements on my behalf**.** This authorization is in effect until revoked by me in writing. **The person(s) will present valid ID for identification purposes and sign forms signifying my parental responsibility for payment.**

____	______________________________
Parent/Legal Guardian Signature	Phone Number
____	______________________________
Parent/Legal Guardian Name (Print)	Date