Authorization to Treat an Unaccompanied Minor

(For established patients 16 years of age and older)

Patient Name:____ Date of Birth:___________________

As a general rule, we require the consent of a patient or legal guardian in order to provide health care services to a minor child (someone under the age of 18). This authorization allows you to approve: (a) that we can treat your minor child for follow up appointments when she/he comes to the office unaccompanied by a responsible adult; and (b) that we can help in a health care emergency. If your minor child presents to the office unaccompanied, we will check that you have signed the authorization to treat your minor child in your absence, and will reschedule the appointment if we do not have your written consent. The provider has the right to cancel or reschedule the appointment until the Parent or Legal Guardian is with the minor, if it is in the best interest of the minor patient or is required by law.

☐ I hereby give permission for my minor child to be seen at Noor Dermatology and Aesthetics when they arrive at the office alone.

This authorization:

❐ For any and all medical treatment
❐ For today only
❐ For this specific problem (s), or a specific date range. Please specify:________________________________

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I have read and fully understand this consent to treat my minor child in my absence. This consent will remain valid and enforceable until it is revoked in writing by me from the date signed unless otherwise specified in writing.

Parent or Legal Guardian: (Print Name)_____________________________ Date:_______________________

Parent or Legal Guardian Signature:____

Witness: (Print Name)________________________________ Signature:______________________________