TREATMENT OF A MINOR CONSENT

Arizona Dermatology Group

I, ____, am the legal guardian/parent of ____, currently a minor, whose date of birth is listed below.

I authorize Arizona Dermatology Group and its medical personnel to provide medical and/or surgical health care to my son/daughter, including, but not limited to, diagnostic examinations, and necessary medical treatment including surgical procedures.

This authorization will remain in effect until my child turns eighteen years of age. I further understand, once my child reaches the age of majority, my consent for treatment is no longer required.

Furthermore, I understand that it is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient's portion at the time services are rendered.

By signing this, I acknowledge that I have read and that I understand this consent.

____ _________________________
Printed Patient Name Date of Birth

____ _________________________
Parent/Legal Guardian Signature Date

____ _________________________
Witness Date