SOUTHERN
INSTITUTE OF DERMATOLOGY

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Authorization to Treat Minors

This form allows parents of Southern Institute of Dermatology patients to have a prior authorization in place so that medical care may be delivered directly to minors if a parent or legal guardian cannot be present.

Be advised that protected patient health information may be shared with the proxy to whom the right to consent has been delegated to facilitate informed decision making.

Authorization

I have the legal right to pre-authorize this facility to deliver medical treatment to my child. I request and authorize Southern Institute of Dermatology and its personnel to deliver care to my child listed below:

Name: _____ DOB: _____

I confirm that the individual(s) listed below are authorized to act as my child's proxy in my absence:

Name/ relationship to patient: _____

Name/ relationship to patient: _____

Limitations

Identify any limitations on the kinds of medical services for which this authorization is given. If none, state none.

_____

_____

Identify any limitations on the time frame for which this authorization is given. If none, state none.

_____

Contact Information

If the nature of the medical care is not routine, please try to contact me regarding the health care of my child at the following telephone numbers. If you are unable for any reason to contact me, you may rely on the proxy decision maker for consent.

Parent Name: _____ Day Phone: _____

Cell Phone: _____

Signature: _____ Date: _____