



Authorization for Treatment of An Unaccompanied Minor

Date: _____

I authorize Affiliated Troy Dermatologists to give follow up treatment for _____, to the minor (Patient Name) _____, (Date of birth) _____ at all unaccompanied visits. Affiliated Troy Dermatologists will be able to get in contact with me by phone at anytime during the visit at the following number _____. If I cannot be contacted, I understand the minor may be sent home without being seen.

I have read and understand the above and agree with these provisions.

Signature of Parent/Legal Guardian

Date

Witness

Date