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### CONSENT TO TREAT A MINOR

Many times parents find themselves unable to accompany their teen or young adult to appointments, or choose not to be in the treatment room with their minor. This form has been prepared for your convenience should you at some time be unable to accompany your child or find it necessary to have a friend or other family member accompany your child to his/her visit. By signing this form you are giving permission for Camelback Dermatology & Skin Surgery to evaluate and treat your child. Please understand that you are responsible for the payment of their copay at the time of the visit.

Effective immediately, I hereby grant CAMELBACK DERMATOLOGY & SKIN SURGERY,

permission to treat my child, \_\_\_\_\_, \_\_\_\_\_ .  
(Print Patient Name) (Date of Birth)

This consent expires on the patient's 18<sup>th</sup> birthday.

\_\_\_\_\_  
**Print Name of Parent/Guardian**

\_\_\_\_\_  
**Signature of Parent/Guardian**

\_\_\_\_\_  
**Date**

*Revised 6-27-11*