MOD Dermatology, PC
Authorization to Treat a Minor Patient When Parents Are Temporarily Unavailable

I, _____ parent or legal guardian of

(Patient Name)_____ (Patient DOB)_____

authorize MOD Dermatology, PC to evaluate and treat the above-named patient. I understand a parent or legal guardian will be required to sign a separate consent for excisions, biopsies, and any invasive or surgical procedure. This consent will remain in effect for 12 months from the date of my signature.

Signature of Parent or Legal Guardian_____ Date _____

Relationship to Patient _____