



## MINOR CONSENT FORM

*\*\*Authorization of parent/guardian for appointed individual to bring their child/minor to the clinic for medical care and treatment:*

I give my consent for (name of parent/guardian) \_\_\_\_\_

(relation to patient) \_\_\_\_\_ to bring

(name of minor/patient) \_\_\_\_\_

(date of birth) \_\_\_\_\_ to Arlington Dermatology

for medical care and treatment.

This authorization is in effect for (date of visit) \_\_\_\_\_ visit.

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*\*\*Authorization of parent/guardian consenting for the patient who is a minor to receive medical care and treatment with NO accompaniment of parent or guardian.*

I, (name of parent/guardian) \_\_\_\_\_ give my

consent for (name of minor/patient) \_\_\_\_\_,

(date of birth) \_\_\_\_\_ to receive medical care and

treatment from Arlington Dermatology on (date of visit) \_\_\_\_\_ visit.

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Parent or legal guardian signature

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Today's date