Advance Consent to Treat Minor Children (under 18 years of age)

I, _____ (name of responsible party), hereby authorize all necessary dermatological treatment, deemed necessary by the dermatologist, for:

Name of Patient: _____

Date of Birth: _____

Miller Family Dermatology may provide treatment if my child is unaccompanied to his or her appointment, or if someone other than myself accompanies my child.

I have read a copy of Miller Family Dermatology's Important Information to Parents and Guardians of Minor Children. I understand a written copy will be provided to me at any time upon my request. I understand Miller Family Dermatology has a link to the Important Information to Parents and Guardians of Minor Children on the practice website located at https://millerfamilydermatology.com/for-patients/parent-and-guardians/.

Signature of Responsible Party (Guarantor): _____

Name (Print): _____ Date:_____

Relationship to Patient: _____ Witness Signature: _____

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