Raleigh Dermatology Associates, PA

800 Springfield Commons Drive, Suite 115 ● Raleigh, NC 27609
Phone: (919) 876-3656 Fax: (919) 876-2351

Fernando R. Puente, MD

Authorization to Consent to Health Care for a Minor Accompanied by Another Adult

I am the custodial parent having legal custody of _____, a minor child, date of birth _____. I authorize _____, an adult in whose care the minor child has been entrusted to do any act which may be necessary or proper to provide for the health care of the minor child at Raleigh Dermatology Associates, PA. I consent to performance of surgeries and other procedures done at Raleigh Dermatology Associates, PA. This consent shall be effective on _____. By signing here, I indicate that I have the understanding and capacity to communicate health care decisions and that I am fully informed as to the contents of this document and understand the full importance of this grant. I understand and agree that I am liable for any and all charges incurred by the treatment of the above patient.

Limitations on such consent and treatment are as follows (if none write none on the line below).

_____

This consent has the following time limitations (if none write none on the line below).

_____

Custodial Parent Contact Information (please print):

_____ _____
Custodial Parent Name Work Phone Number

_____ _____
Home Phone Number Mobile Phone Number

_____ _____
Custodial Parent Signature Date

_____ _____
Witness Date