

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

I am the custodial parent having legal custody of _____, a minor child, date of birth _____. I authorize my child to consent to any medical treatment and/or procedures provided to the health care of the minor child 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