CHARLOTTESVILLE DERMATOLOGY

ANNA MAGEE MD ■ DEBORAH ELDER MD ■ CHELSI MILLER NP

MINOR CHILD MEDICAL AUTHORIZATION FORM

It is the policy of Charlottesville Dermatology to have a parent or legal guardian present during a minor patient's initial visit. This helps the parent/guardian have a comprehensive understanding of your child's care and treatment options.

In the event that you, as parent or guardian cannot be present during a future visit(s) please complete the below listed authorization for the care of your child.

I, the undersigned, and parent(s) of _____, hereby authorize (name of person to accompany child)_____, to authorize any and all medical treatment for (name of minor child) _____they, in their discretion, see fit. This includes, but is not limited to examination and treatment.

A photocopy of this authorization shall be deemed effective as if it were an original. This authorization shall remain in effect until _____ ____, 2012.

MEDICAL INSURANCE COMPANY: _____

MEDICAL INSURANCE ID or GROUP #: _____

MEDICAL INSURANCE CO. PHONE #: _____

POLICY HOLDER NAME AND DOB: _____

PEDIATRICIAN/PCP NAME PHONE #: _____

_____ _____

Parent/Legal Guardian Date

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