SWANN DERMATOLOGY PARTNERS

CONSENT TO TREAT MINOR WITHOUT PRESENT PARENT/GUARDIAN

I _____ do hereby state that I am the parent/legal guardian
(Name)

of _____, a minor of _____ years, born on
(Minor's Name) (Age)

_____ who resides with me at _____
(Birth Date) (Address)

_____.

In my absence, I authorize _____, to consent to any necessary
(Minor's Name)
examination, medical diagnosis, treatment (medical or cosmetic in nature) to be rendered to the above-named minor under the general or special supervision and on the advice of any physician or cosmetic provider licensed to practice in the state of Missouri.

The authorization shall be limited to the following time period: _____

If no time period is specified, this authorization will remain valid until patient's 18th birthday.

I accept responsibility for all charges related to any medical or cosmetic treatment rendered by reason of this authorization.

_____
(Parent/Guardian Name- Print)

_____ _____
(Parent/Guardian Name- Signature) (Today's Date)

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