STX SOUTHTEXAS DERM DERMATOLOGY
4141 S. Staples, Ste. 300
Corpus Christi, Texas 78411
PHONE: 361-882-5560
FAX: 361-882-6011
info@southtxderm.com
southtxderm.com

CONSENT FOR THE TREATMENT OF A MINOR

PATIENT NAME: _____

DATE OF BIRTH: _____ **AGE:** _____

SECTION A: PARENT / LEGAL GUARDIAN / AUTHORIZED REPRESENTATIVE CONSENT

I certify that I am the parent, legal guardian, managing conservator, or authorized representative of the abovenamed minor and authorize the provider to render medical evaluation, diagnosis, and treatment deemed medically necessary, including office visits, diagnostic testing, minor procedures, medications, immunizations, telemedicine (if applicable), and emergency care. I understand the risks, benefits, and alternatives have been explained. No guarantees have been made regarding outcomes. I authorize release of medical information as permitted by law.

PARENTS NAME: _____ **PHONE:** _____

SIGNATURE: _____ **DATE:** _____

SECTION B: AUTHORIZATION FOR DESIGNATED ADULT (MUST BE 18+ YEARS OLD) TO ACCOMPANY AND CONSENT FOR MINOR'S MEDICAL CARE

I, the undersigned parent/legal guardian of the above-named minor, authorize the following individual to:

- Accompany my child to medical appointments
- Receive medical information related to the visit
- Consent to routine medical evaluation and treatment
- Consent to diagnostic testing and laboratory services
- Consent to minor dermatologic procedures (e.g., biopsies, cryotherapy, lesion removal)
- Receive prescriptions and treatment instructions

Name of Designated Adult: _____

Relationship to Minor: _____

Driver's License / ID Number: _____

PARENTS NAME: _____ **PHONE:** _____

SIGNATURE: _____ **DATE:** _____

SECTION C: CONSENT FOR MINOR TO BE SEEN WITHOUT PARENT/GUARDIAN PRESENT (MUST BE AT LEAST 15 YEARS OLD)

I, _____, am the: ☐ Parent ☐ Legal Guardian ☐ Managing Conservator

of the above-named minor.

I give permission for my child to be evaluated and treated at SOUTH TEXAS DERMATOLOGY without me being physically present in the examination room and/or office during today's visit.

PARENTS NAME: _____ **PHONE:** _____

SIGNATURE: _____ **DATE:** _____

***THIS FORM IS VALID FOR ONE YEAR FROM DATE OF SIGNATURE, PLEASE LET THE FRONT OFFICE CLERK KNOW IF YOU NEED TO UPDATE OR CHANGE THIS FORM.**