Anne Arundel DERMATOLOGY

Affiliates of Anne Arundel Dermatology

Administrative Offices & Billing Services
1306 Concourse Drive, Suite 201 | Linthicum MD 21090 | Tel: 410-544-7692 Fax: 410-431-8935

Central Scheduling Office
443-351-DERM(3376)

CONSENT FOR MINORS IN ABSENCE OF PARENT

Parental Consent to Treatment of a Minor

(I) (We), the undersigned, parent(s)/legal guardian(s) of _____,
Hereinafter "Minor", do hereby grant permission to Anne Arundel Dermatology and their affiliates to treat in (my) (our) absence for any medical, cosmetic or surgical diagnosis or treatment which is deemed advisable by, and is rendered at one of our dermatology offices outlined above.

It is understood that this authorization is given in advance of any specific diagnosis, treatment or care being required, to grant consent for the treatment of the aforementioned minor in (my) (our) absence.

This authorization shall remain in effect:

☐ Through the _____ day of _____, 20_____.

☐ Until age 18

Name of person(s) authorized to accompany minor during visit and be disclosed office visit or historical health information, please print:

_____ _____ _____

Persons listed above must show valid ID at time of visit

Parent or Legal Guardian:

_____ _____ _____
NAME SIGNATURE DATE

Parent or Legal Guardian:

_____ _____ _____
NAME SIGNATURE DATE

Witness:

_____ _____ _____
NAME SIGNATURE DATE