

SORKIN DERMATOLOGY

PERMISSION TO TREAT A MINOR

I _____ give permission to my child _____
(name of guardian/parent) (name of child under the age of 18)
to attend his/her appointment alone without my presence and authorize treatment for my child in accordance with the office policy of SORKIN DERMATOLOGY. This includes providing a history of present illness/condition, disclosure of protected health information, and responsibility for relaying any diagnosis, treatment, or prescription(s) to the parent or legal guardian listed above. I agree to be available by phone and to be financially responsible for all co-pays and coinsurance. This authorization is effective on:

_____ and expires _____.
(Today's date) (Date authorization is not valid)

(Signature of Parent/Legal Guardian)

Child's Name _____ Child's DOB _____

Parent's Home # _____

Parent's Cell # _____

Parent's Work# _____

Where can you be contacted in case of emergency? _____

Comments: _____

Health Insurance Information

***If no change, skip to next section**

New Insurance information listed below:

Insurance Company _____

Policy Holder _____

ID Number _____

Group Number _____

Effective Date _____

Co-pay _____

Child's Health Information

Currently prescribed or over-the-counter medications and doses:

Allergies, illnesses or other information?