AUTHORIZATION TO TREAT MINORS
Holland Dermatology

Patient Name: ________________________________ Date of Birth: ___/___/___

Many times parents/guardians find themselves unable to accompany their teen or young adult children to appointments. This form has been prepared for your convenience should you at some time be unable to accompany your child. If your child is being accompanied by another adult, for example, a grandparent, sibling, or sitter, please list who may act on your behalf for treatment and updating/signing paperwork.

I _______________________________________, as parent or legal guardian, hereby grant:
(print name)

A) **Dr. Barbara Drozdowski** permission to treat this minor patient when accompanied on my behalf to Holland Dermatology by the following adults:

____ ___________________________
Name Relationship to Patient

____ ___________________________
Name Relationship to Patient

____ ___/___/___
Signature of Parent/Legal Guardian Date

B) **Dr. Barbara Drozdowski** permission to treat this minor patient completely unaccompanied by any adult.

____ ___/___/___
Signature of Parent/Legal Guardian Date

(signature is valid for one year from the date signed)