Kittridge Dermatology

PARENTAL PREAUTHORIZATION FOR MEDICAL CARE TO MINORS

If the circumstance arises that a parent or guardian cannot physically be present for the evaluation and/or treatment of a minor it is necessary to have a prior authorization for medical care delivered to minors without a parent/guardian present. Please review the following authorization for treatment and complete the information if you wish to authorize such treatment.

I request and authorize Kittridge Dermatology and its personnel to deliver medical care to my child listed below:

_____ _____

Name Date of Birth

If necessary I can be contacted regarding health care of my child at the following numbers:

_____ _____

Name of Parent/legal Guardian Phone- home/office/cell

_____ _____

Name of Parent/legal Guardian Phone- home/office/cell

_____ _____

Other- List Relationship Phone- home/office/cell

_____ _____

Signature of Legal Guardian Date

_____

Print Name and Relationship

Note: If there are any special family relationships please explain in the space below with your signature, printed name and phone number where you can be contacted.

_____

_____