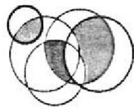
READING DERMATOLOGY
MEDICAL, COSMETIC & SKIN CANCER CENTER

Authorization for Treatment of Minor Patient

Dr. Dean Burget, MD
Dr. Jason Hendrix, DO
Dr. Stephen Schleicher, MD
Amy Hendrix, CRNP
Jamie LaPorte, PA-C
Todd Staub, NP-C
Kelly S. Mickulik, PA-C

Name of Patient: ____________________________________ **Date of Birth:** _________________

Reading Dermatology Associates recognizes there are times when a parent or legal guardian may not be able to accompany a child to an appointment and must (1) rely on a family member or friend to accompany the child or (2) may choose to allow the child (age 15-17 only) to attend the appointment unaccompanied by an adult. We understand these circumstances; however, we must have your written authorization allowing an adult you specifically identify to accompany your child or permitting the child to attend alone. If you provide consent for us to treat your unaccompanied child, you understand that care will proceed at the discretion of the healthcare provider. **The person accompanying the child must be an adult (age 18 or above), and must present a photo identification at the time of the visit.**

☐ **ONLY PARENT/GUARDIAN MAY ACCOMPANY CHILD FOR TREATMENT**

I, ____, **DO NOT** authorize anyone other than the child's father, mother, and/or legal guardian to accompany my child to Reading Dermatology Associates for the provision of medical services.

☐ **AUTHORIZATION TO PERMIT CERTAIN ADULTS TO ACCOMPANY CHILD FOR TREATMENT:**

I, __________________________________, hereby authorize the following adults(s) to accompany my child to Reading Dermatology for medical services, and to view or discuss my child's Protected Health Information (PHI) when accompanying my child.

Name(s) of authorized adult(s): *Please print*

____ ________________________________
Last name, First name Relationship to patient

____ ________________________________
Last name, First name Relationship to patient

This/These individual(s) are able to authorize medical services, including: ☐ **Biopsy** ☐ **Liquid Nitrogen**

☐ **CONSENT TO TREAT <u>UNACCOMPANIED</u> MINOR (AGE 15-17 ONLY) AT READING DERMATOLOGY:**

I, __________________________________, request and authorize Reading Dermatology Associates and its personnel to delivery medical care and services to my **MINOR CHILD** identified above.

I/We may be reached at the following telephone numbers during my child's appointment (s):

____
Parent/Guardian's Name Primary Contact Number Alternate Contact Number

____
Parent/Guardian's Name Primary Contact Number Alternate Contact Number

____
PRINT NAME **RELATIONSHIP** **SIGNATURE** **DATE**

3317 Penn Avenue, West Lawn, PA 19609 Phone: 610-750-7891 Fax: 610-750-7896
After Hours Urgent Matter Only 610-223-4871