

Alaska Center for Dermatology, P. C.

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Authorization for Minor Alone

Patient Name _____ **DOB** _____

I, *(printed name)* _____, make an oath that I am the lawful guardian of the child listed above, and I authorize for them to be examined and treated by the Alaska Center for Dermatology in my absence.

I acknowledge that no guarantees have been made to me as to the effect of such examinations or treatment of my child's condition and that I am responsible for all charges incurred. This authorization will remain in effect for one year from the date signed unless canceled sooner in writing.

I can be reached at *(phone number)* _____ with any questions.

Parent/Legal Guardian Printed Name

Parent/ Legal Guardian Signature

Date

Expiration Date *(one year from signature date)*