ARIZONA ADVANCED DERMATOLOGY

DISEASES OF THE SKIN **CUTANEOUS LASER SURGERY** **COSMETIC DERMATOLOGIC SURGERY**

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AUTHORIZATION TO TREAT A MINOR IN THE ABSENCE OF PARENT/GUARDIAN

Date: _____

Name of Minor: _____

Date of Birth: _____

Name of Parent(s)or Guardian(s): _____

Person(s) authorized to bring named Minor: _____

Relationship to Minor: _____

This authorization is in effect from _____ to _____.

_____
SIGNATURE of Parent or Guardian

_____ _____
PLEASE PRINT NAME Relationship to Patient

_____
WITNESS

A copy of your driver's license, or other appropriate identification may be requested.
If you are a legal guardian to this minor, please provide guardianship documents.

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