Anne Arundel DERMATOLOGY

and Affiliate Practices

Consent to Treat an Unaccompanied Minor

(For established patients 16 years of age and older)

Patient Name:___________________________________ Date of Birth: __________________

As a general rule, we require the consent of a patient or legal guardian in order to provide health care services to a minor child (someone under the age of 18). This authorization allows you to approve: (a) that we treat your adolescent child for follow up appointments when s/he comes to the office unaccompanied by a responsible adult; and (b) that we can help in a health care emergency. If your minor child presents to the office unaccompanied, we will check that you have signed the authorization to treat your adolescent child in your absence, and will reschedule if we do not have your written approval. The provider has the right to cancel or reschedule the appointment until the Parent or Legal guardian is with the minor, if it is in the best interest of the minor patient or is required by law.

☐ I hereby give permission for my adolescent to be seen at a Anne Arundel Dermatology office when they arrive at the office alone.

This authorization is valid:

- ☐ For any and all medical treatment.
- ☐ For today only.
- ☐ For this specific problem(s) or a specific date range. Please specify:

I have read and fully understand this consent to treat my adolescent in my absence. This consent will remain valid and enforceable (do what it allows) until it is revoked (canceled) in writing by me from the date signed unless otherwise specified in writing.

Parent or Legal guardian: (Print Name) ________________________________ Date: ___/___/____

Parent or legal guardian signature: ___________________________________

Witness: (Print Name) ________________________________ Signature:___________________________

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AUTHORIZATION TO CONSENT TO HEALTH CARE FOR A MINOR

I____, of (city or county)________________________ state of _______________ am the custodial parent having legal custody of________________________________,minor child, age ________ ,born ____________________. I authorize any physician, physician assistant, or health care provider employed by or affiliated with, or working for Anne Arundel Dermatology, P.A. and Affiliates to do any acts which may be necessary to provide for the health care of the minor child, including but not limited to the power (I) to provide for such health care at any hospital or other institution, or the employing of any physician, nurse, or other person whose services may be needed for such health care, and (II) to consent to and authorize any health care, including performance of surgeries, and other procedures by physicians, and other medical personnel, except the withholding or withdrawal of life-sustaining procedures. This consent shall be effective from the date it is executed until the date I terminate it in writing. By signing here, I indicate that (I) I have the understanding and capacity to recognize the importance of, to communicate, and assign the health care decisions covered by this document. I am fully informed as to the contents of the document, and (II) I understand the full scope and importance of this grant of powers to the agent named herein.

I authorize the following parties listed below to consent for treatment as well as above:

_______________________________ _______________________________

_______________________________ _______________________________

_______________________________ _______________________________

(Custodial Parents Signature) (Date)

****FOR NOTARY USE ONLY****

State of ____

County of______________________________________

On this__________day of________________________________personally appeared before me, the said named

____,to me known and known to me to be the person described in and who executed the foregoing instrument, and that person acknowledges that he (she) executed the same and being duly sworn by me, made the oath the statements in the foregoing instrument are true.

____, Notary Public (Official Seal)

My Commission Expires:___________________________

NO CHILD UNDER 18 YEARS OF AGE, SHALL BE SEEN WITHOUT A CONSENT FORM SIGNED BY THE CUSTODIAL PARENT AND ACKNOWLEDGED BEFORE A NOTARY PUBLIC ACCORDING TO THE N.C. SENATE BILL 955. SECTION I, CHAPTER 32A OF THE GENERAL STATUES. THE COMPLETED CONSENT FORM SHALL BE PLACED IN THE PATIENTS MEDICAL CHART.