

DERMATOLOGY ASSOCIATES OF MORRIS, P.A.

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**Consent to Treat Minors**

If someone other than the parent brings your child in for an appointment, we must have the parent's written authorization in order to provide medical care.

I, \_\_\_\_\_, the parent or legal guardian of  
\_\_\_\_\_, Date of Birth \_\_\_ / \_\_\_ / \_\_\_\_\_, authorize my child to  
be treated.

Also, I authorize \_\_\_\_\_ to bring my child in for medical  
treatment and to receive my child's Patient Health Information. Their relationship to  
patient: \_\_\_\_\_

Treatment may include:

- General and ongoing medical care
- Minor surgery which may be accompanied by the administration of local injectable  
lidocaine

This authorization is effective:

- Today Only \_\_\_ / \_\_\_ / \_\_\_\_\_
- From \_\_\_ / \_\_\_ / \_\_\_\_\_ to \_\_\_ / \_\_\_ / \_\_\_\_\_

Parent or Legal Guardian Signature: \_\_\_\_\_

Date: \_\_\_\_\_