WINSTON SALEM DERMATOLOGY & SURGERY CENTER, PLLC

CONSENT RELATING TO TREATMENT OF A MINOR PATIENT

Patient Name:_____ Date of Birth:_____

To facilitate medical care and treatment of my child, _____, ("Minor Patient"), by Winston Salem Dermatology & Surgery Center, PLLC and their providers and/or staff, the undersigned parent or legal guardian of the Minor Patient hereby agrees as follows:

1. I am a parent or legal guardian of the Minor Patient authorized to make health care decisions on behalf of the Minor Patient.

2. I authorize Winston Salem Dermatology & Surgery Center, PLLC to engage in the following:

   - ☐ Direct Authorization For Treatment by Winston Salem Dermatology & Surgery Center. I authorize Winston Salem Dermatology & Surgery Center, PLLC to provide the Minor Patient with emergency, urgent and other medical care and treatment in my absence. (This allows a minor patient to come to an appointment(s) unaccompanied by parent/guardian/parent substitute.)

   - ☐ Appointment of Parent Substitute to Authorize Care and Treatment for Minor Patient. I authorize the Parent Substitute designated below to give informed consent for emergency, urgent and other medical care and treatment for the Minor Patient.

3. **Identification of Parent Substitute**. I appoint the following Parent Substitute(s) to obtain access to Protected Health Information, and give informed consent for care and treatment.

Name	**Relationship to Minor**	**Phone Number**
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. **Duration**. This authorization is valid for a maximum period of two (2) years from the date signed, unless a shorter duration is specified, commencing on _____ and expiring on _____. This authorization may be revoked at any time prior to that expiration date by providing Winston Salem Dermatology & Surgery Center, PLLC with written notice. Please send the written notice to Privacy Officer, Winston Salem Dermatology & Surgery Center, PLLC, 1400 Westgate Center Drive, Suite 200, Winston-Salem, NC 27103.

5. **Release**. I agree to release Winston Salem Dermatology & Surgery, PLLC from liability for any claims resulting from Winston Salem Dermatology & Surgery provision of patient care and release of Patient Health Information in reliance upon this authorization.

I have carefully read and considered this consent form before signing it.

SIGNATURE OF PARENT OR LEGAL GUARDIAN:

_____ _____

Signature Date

Legal Authority:

- ☐ Parent of Minor
- ☐ Legal Guardian

CONTACT INFORMATION CONCERNING PARENT OR LEGAL GUARDIAN:

_____	_____	_____
Name	Relationship to Minor	Contact Phone Number
_____	_____	_____
Name	Relationship to Minor	Contact Phone Number