REGIONAL DERMATOLOGY OF DURHAM, PLLC
4321 MEDICAL PARK DRIVE SUITE 102
DURHAM, NC 27704 919/220-7546

Consent for Treatment of Minor Child

I, being the parent or guardian of _____
(Patient Acct#_____),do hereby request and authorize Dr. _____ and his/her staff to perform necessary services for my child which are deemed advisable by the physician, whether or not I am present at the actual appointment. An authorized adult (18 years or older) must be present for each visit (see list below). Please note there may be some procedures and/or medications that a parent or guardian must be present for.

Whoever signs this consent form is responsible for any charges incurred.

Below is a list of individuals who have permission to bring my child in for treatment:

_____

_____

_____

_____

_____

_____

Name of Parent or
Legal Guardian Signing Below: _____
Print Name

Date of Birth (Parent or Legal Guardian): _____

Work Phone: _____

__ _____ __ _____

Signature of Parent or Guardian Date and Time

_____ _____

Witness Date and Time