

Patient ID#: _____



BRYN MAWR DERMATOLOGY

CONSENT FOR MINOR TO BE SEEN WITH ADULT OTHER THAN A LEGAL GUARDIAN

Name of Patient: _____

Date of Birth: _____

I authorize the following individual(s), who are 18 years or older, to stand in as legal guardian for medical visits at Bryn Mawr Dermatology. I delegate medical decision making to these individuals, which may include but is not limited to: receiving new diagnoses, updating the status of previous diagnoses, continuing current treatment modalities or modifying treatments as the provider sees fit.

(Person bringing child to appointment)

(Relationship to child)

(Person bringing child to appointment)

(Relationship to child)

(Person bringing child to appointment)

(Relationship to child)

This consent is valid until revoked in writing by me, the parent/legal guardian or until the patient reaches the age 18 years old.

I have the legal right to make decisions for this minor and agree to the statement above.

Signature of Parent or Guardian

Printed Name

Date

Contact information for parent/guardian:

Phone Number