Advanced Dermatology Laser and Cosmetic Surgery
35 West End Ave, Prof. Suite 2, Brooklyn, NY 11235
Tel: (718) 375-7546 Fax: (718) 513-4561
Nyskinclinic.com Levitdermatology.com

PERMISSION TO TREAT A MINOR

Only for children age 16 - 18 years

All younger children must be accompanied by their parents/legal guardians

I ________________________________ give permission to my child ________________________________
(Name of Parent/Guardian) (Name of child age 16-18 years)

to attend his/her illness appointment alone without my presence and authorize treatment for my child in accordance with the office policy of Advanced Dermatology Laser & Cosmetic Surgery. This includes providing a history of present illness, disclosure of protected health information, and responsibility for relaying any diagnosis, treatment plan, or prescription(s) to the parent or legal guardian mentioned above. I agree to be available by phone and to be financially responsible for all co pays and coinsurance.

This authorization is effective on:

_____________________________________ and expires ____
(Today's Date) (Date authorization is no longer valid)

Emergency Contact Information for Parents/Guardians:

Where/how can you be contacted in case of emergency?____

Phone: ____

E-mail address: ____

Parent of Legal Guardian's Signature: _________________________________Date: _____________________

- *Please print and bring the permission form with you for your appointment. Please be aware that the medical staff will not be able to provide care without proper documentation.*
- *Пожалуйста, распечатайте и возьмите с собой бланк разрешения на визит. Пожалуйста, имейте в виду, что медицинский персонал не сможет обеспечить уход без надлежащей*

Thank you.