MINOR CONSENT AUTHORIZATION

This Minor Consent Authorization (hereinafter referred to as "Consent") shall serve as permission for established patient, ____, to be treated without my presence in the office at Tarrant Dermatology Consultants, P.A. or Dermatology Associates of Parker County. Treatment may only include established follow-up office visits and excludes all procedures. A Consent will not be recognized for new patients.

Furthermore, this Consent will only be recognized for patients who are age sixteen or age seventeen. Any patient who is age fifteen or younger must be accompanied by their parent or legal guardian to all visits.

If a parent or legal guardian is not present at the time this Consent is submitted, their valid and current driver's license must be submitted with the Consent. This authorization will remain in effect for one year unless the Practice Manager voluntarily revokes the Consent, or the patient's parent or legal guardian revokes the Consent in writing.

I, ____, (parent / legal guardian name), authorize ____, (patient name) to be treated by Tarrant Dermatology Consultants, P.A. or Dermatology Associates of Parker County without my presence in the office under the conditions as described above.

____	____________________	
Patient Name	Date of Birth	
____	____________________	____________________
Parent/Guardian Signature	Relationship to Patient	Date