Russell Dermatology of Conway

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Authorization for Medical Treatment of Minors

Name of minor_____ Birth date_____

I/we, being the parent(s) or legal guardian(s) of the above named minor, do hereby appoint

Name(s)_____ Relationship to Patient:_____.

Address_____ Phone:_____

Name(s)_____ Relationship to Patient:_____.

Address_____ Phone:_____

to act in my/our behalf in authorizing medical, or surgical care for the above named minor during the period of my/our absence

from Month Day Year _____ **through** Month Day Year _____

Signature of parent or guardian:_____ Date: _____

Address:_____ Phone:_____