ALTA VISTA DERMATOLOGY

206 W. County Line Rd., Suite 340
Highlands Ranch, CO 80129

Consent for Medical Care of Minors

Colorado requires consent of a parent or legal guardian for medical care of a minor with or without you present. This consent is convenient to have on file such that minors can undergo and receive treatment at Alta Vista Dermatology without having you present. Please review the following consent for medical treatment and complete the information to authorize such treatment of a minor.

I, the parent/legal guardian authorize, request and direct a performance such as medical or minor surgical procedures as deemed necessary by the healthcare professionals of Alta Vista Dermatology.

I further understand that I am responsible for the cost of such a medical treatment whether or not such a medical treatment is covered by my insurance. I agree to pay any and all costs incurred by the above named minor patients to Alta Vista Dermatology.

AUTHORIZATION

I (we) request and authorize Alta Vista Dermatology to deliver medical care to my (our) children listed below:

_____ _____
NAME DATE OF BIRTH

_____ _____
NAME DATE OF BIRTH

_____ _____
NAME DATE OF BIRTH

Please try to contact me (us) regarding health care of my (our) children at the following phone numbers:

_____ _____
NAME OF PARENT PHONE – OFFICE/HOME

_____ _____
NAME OF PARENT PHONE – OFFICE/HOME

_____ _____
OTHER RELATIONSHIP PHONE – OFFICE/HOME

Addendum: If there are any special parental or custodial relationships (such as custody with one parent only, legal custody/guardianship with non-parent, etc), please explain in the space below with your signature, print name, and phone number at which you can be contacted.

Signature of Parent/Legal Guardian *Date*