Premier Dermatology, PLLC

Parental Pre-Authorization for Medical Care to Children

For families who are ongoing patients of Premier Dermatology, PLLC, it may be more convenient to have prior authorization for medical care delivered directly to minors (under the age of 18) without a parent having to be present prior to treatment. Please review the following authorization for treatment and complete the information if you want to authorize such treatment in advance.

AUTHORIZATION

I (we)_____request and authorize Premier Dermatology, PLLC and its personnel to deliver medical care to my (our) child(ren) listed below:

PLEASE PRINT
Name:_____
DOB:_____

Name:_____
DOB:_____

Name:_____
DOB:_____

Please try to contact me (us) regarding health care of my (our) child(ren) at the following phone number(s):
Parent's name:_____
Phone: Home_____office_____cell_____

Other (relationship):_____ Phone:
Home_____office_____cell_____

Signature:_____
Date:_____
PRINT name and relationship:
_____

NOTE: 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, printed name, and phone number at which you can be contacted.
_____
_____
_____
_____