

Dermatology Associates, PC/Beth Honl, M.D.
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AUTHORIZATION FOR TREATMENT OF A MINOR

NOTICE TO PARENTS

Parents often find it difficult to accompany their minor children to routine follow up appointments. This form has been created to give you the opportunity to authorize treatment for your minor child in your absence. Note: A parent/guardian is required to be in attendance on the minor's first office visit to review and sign the minor's consent for care initial paperwork.

Patient Name _____ **Patient Date of Birth** _____

AUTHORIZATION FOR TREATMENT OF A MINOR

I authorize **Dr. Beth Honl** to render treatment to my minor child (Child's Name) _____, without my presence in the office.

Signature: _____ **Date:** _____