Authorization for Treatment of a Minor

#1

In my absence I hereby authorize the providers and staff of Paragon Health, PC DBA Southwest Michigan Dermatology to administer treatment or medication and perform any procedures as may be deemed medically necessary for the diagnosis and treatment of _____ DOB _____, a minor 16 years or older.

Minor may be treated without parent or adult present.

_____ _____
Authorizing Person (Parent or Guardian) Witness

_____ _____
Relationship to Patient Date

Or #2

Authorized Person(s) other than Parent or Legal guardian

I hereby authorize _____ to authorize treatment, medication, or procedures as may be deemed medically necessary for the diagnosis and treatment of _____, a minor.

Above named adult(s) must be present for the minor to be treated.

_____ _____
Authorizing Person (Parent or Guardian) Witness

_____ _____
Relationship to Patient Date

Or #3

I do not authorize anyone, other than Parents or a legal guardian, to authorize treatment, medication, or procedures as may be deemed medically necessary for the diagnosis and treatment of _____, a minor

_____ _____
Authorizing Person (Parent or Guardian) Witness

_____ _____
Relationship to Patient Date